Thank you for your interest in services provided by Shepherd Center. We appreciate the opportunity to work with you and your client to maximize function and quality of life. Typically, a Comprehensive Diagnostic Evaluation (CDE) or a Rehab Upgrade Evaluation (CARE) is scheduled over four to five days. These evaluations can be done either as an inpatient or Day Program or outpatient depending upon which is medically necessary.

To begin the process, please answer the following questions:

**Patient’s Name:**

**Address:**

**Phone #:**

**Date of Birth:**

**Social Security Number:**

**Legal Next of Kin:**

**Address:**

**Phone #:**

**Insurance Company:**

**Policy Number:**

**Adjuster Name:**

**Phone #:** **Fax:**

**DME Vendor**:

**Contact information:**

**Injury Level:**

**Date of Injury:**

**Cause of Injury:**

**Co-Morbidities**:

**Allergies:**

**Height: Weight**

**Current Medications:**

**Describe the client’s current bowel and bladder program and note if the client is independent, continent, and/or needs assistance:**

**List the DME the client currently uses:**

**Does the client have pain issues? If so, where is the pain, and what is the current pain management regimen? List the name and contact number for the physician prescribing the pain treatment.**

**Does the client have issues with spasticity? If so, how is this managed?**

**Can the client feed him/herself? List any adaptive equipment used. Please note if the client has PEG and is on tube feedings and include the feeding schedule.**

**Please describe the amount and type of assistance the client requires for ADLs. Note if the client is assisted by a family member, home health agency, personal care attendant. Include contact information of home health agency, if applicable.**

**Does the patient use any assistive communication device or assistive technology? If, so please describe.**

**Does the patient use any splints or positioning devices? If so, please describe and note the schedule.**

**Does the client receive any outpatient therapy?**

**Company:**

**Contact person: Phone: Fax:**

**List any specific questions or issues that you would like addressed during the assessment. Specify whether this is for an evaluation and treatment, or evaluation only with treatment recommendations. Note whether an inpatient evaluation is requested or whether the evaluation is to be performed in the outpatient setting.**