Shepherd Center

Assistive Technology Center Referral Form

This form should be completed by your physician to make a referral for our Assistive Technology Center.

Patient Information

Name:_____ Date of Birth:_____ SSN:_____
Address: _____
City:_____ State:_____ ZIP Code:_____
Home Phone:_____ Cell Phone:_____ E-mail:_____

Diagnosis and ICD-10 Code: _____

Assistive Technology

OT or ST for Assistive Technology Evaluation and Treatment

☐ ST for evaluation and treatment for speech generating device
☐ OT or ST for electronic device access in the AT Center

Driving

OT Evaluation and Treatment for Driver Rehabilitation/Community Mobility

☐ Driver's License ☐ Learner's Permit License/Permit #:_____ Expiration:_____
Has the patient had a seizure or episode withing the last year? ☐ Yes ☐ No Date:_____
Current medications that may affect safe driving:_____
Do you recommend any driving restrictions? Please specify below:
_____

Seating and Mobility

PT or OT Evaluation and Treatment for Seating and Mobility

☐ Manual Wheelchair ☐ Power Wheelchair ☐ Wheelchair Training
☐ Posture Adjustment ☐ Pressure Ulcer/Pressure Map ☐ Power Assist Eval
☐ Other (please specify:) _____

Seating Clinic Visits

Do you know your Equipment Supplier? If so, please indicate below:
Company Name:_____ Phone:_____
Insurance Type: ☐ Medicare ☐ Medicaid ☐ Private Insurance_____ ☐ VR ☐ VA

Referral Source

Physician Name:_____ Phone:_____ Fax:_____
Address: _____
City:_____ State:_____ ZIP Code:_____

Please attach the patient's most recent medical history and physical or chart note.

Physician Signature:_____ **Date:**_____
**Must have MD signature (cannot be a proxy). Appointment will not be scheduled without signature.*

Please fax this form (along with patient's medical history & physical) to 404-350-7356.
Patients who are not contacted within three business days should call 404-355-1144 and ask for Outpatient Scheduling.