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.

Shepherd Center

Vision Exam and Approval for Driving Evaluation

Patient Information

Name:_____ Date of Birth:_____
Address: _____City:_____ State:_____ ZIP Code:_____
Home Phone:_____ Work Phone:_____

In regard to the request to resume safe independent driving, this form must be completed by your ophthalmologist, optometrist or low-vision specialist specifically addressing the following visual areas related to driving.

Shepherd Center is unable to perform the pre-screen or the on-the-road evaluation without first obtaining this signed form if a visual concern is present due to disability.

Date of Exam:_____ ☐ Corrective lens: Near ☐ Distance ☐ Both ☐
Diagnosis:_____ ☐ Telescopic lens: Type: _____ Power: _____

Corrected visual acuity	Right	Left	Both	Comments
Horizontal visual fields in degrees				☐ Goldman ☐ Humphrey ☐ Confrontation
Peripheral vision				
Saccades				
Range of motion				

Color Vision: Intact ☐ Impaired ☐ Comments: _____
Night Vision: Intact ☐ Impaired ☐ Comments: _____
Depth Perception: Intact ☐ Impaired ☐ Comments: _____
Diplopia: Absent ☐ Present ☐ Comments: _____
Do you recommend any driving restrictions? Please specify below:

_____

Referral Source

Physician Name (print or type):_____
Address: _____City:_____ State:_____ ZIP Code:_____
Phone:_____Fax:_____

I understand by signing this form the above-named person has met state requirements for vision in regard to driving and is visually appropriate to pursue a driving evaluation.

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.