



8100 Penn Avenue South, Suite 137
Bloomington, MN 55431

Office: 952-921-8334
Mobile: 612-968-0832
sue@lifelifetherapysolutions.com

www.TechnologyforHome.org

Office Use Only	Received <input type="text"/>
<input type="radio"/> SR <input type="radio"/> KP	
<input type="radio"/> JH <input type="radio"/> KR	
<input type="radio"/> Other	

Person ID Number: <input type="text"/>	Referral Date: <input type="text"/>	Visit Date: <input type="text"/>
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Person Contact Information	DOB: <input type="text"/>
Name: <input type="text"/>	
Address: <input type="text"/>	
City: <input type="text"/>	Zip: <input type="text"/>
Phone: <input type="text"/>	
Email: <input type="text"/>	
County/Tribe: <input type="text"/>	

Guardian Contact Information	(Address Same As Above) <input type="checkbox"/>
Guardian Name: <input type="text"/>	
Address: <input type="text"/>	
City: <input type="text"/>	Zip: <input type="text"/>
Guardian Phone: <input type="text"/>	
Guardian Email: <input type="text"/>	

County/Tribe Contact ID Number: <input type="text"/>
Contact Name: <input type="text"/>
Contact Title: <input type="text"/>
Phone: <input type="text"/>
Email: <input type="text"/>
Fax: <input type="text"/>

Visit # <input type="text"/>	Visit Time <input type="text"/>
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Consultant:
<input type="text"/>

<input type="text"/>

AT Activity:
<input type="text"/>

AT Goal: <input type="text"/>

Predominant Diagnosis: <input type="text"/>	ICD-10 code: <input type="text"/>
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Currently In Home Goal to be in own Home

Interpreter Needed: <input type="text"/>

Home Care Service	<input type="checkbox"/> Home health aide
<input type="checkbox"/> PDN	<input type="checkbox"/> SN
<input type="checkbox"/> PCA	<input type="checkbox"/> OT, PT, RT, or ST

Waiver Service <input type="checkbox"/>	<input type="checkbox"/> CAC
<input type="checkbox"/> Brain Injury	<input type="checkbox"/> CADI
<input type="checkbox"/> DD	<input type="checkbox"/> Elderly Waiver

Mental Health Service	<input type="checkbox"/> ARMHS
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Other: <input type="text"/>

Person Disabilities / Goals and Special Instruction / Equipment Needed:
<input style="height: 200px;" type="text"/>

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Person ID Number:

Referral Date:

Visit Date:

Visit #

Location of Consultation:
 Home Work Place Cnty/Tribal Office
 E-mail Video Conf Phone

Other:

Others in attendance at AT session (number):
 Family / Guardian: Home Care / Therapies:
 County / Tribal / State: Others:

Technology For Home Follow-up:
Immediate Activities:

- Send report to Person via secure email
- Consultant to write letter of Medical Necessity
- Consultant to call County/Tribe
- Consultant to call AT vendor(s)
- Office to call County/Tribe
- Office to call AT vendor(s)
- Schedule visit after equipment arrives
- Home Mod (2 bids) needed, office to schedule
- Home Mod (2 bids) needed, consultant to schedule

 Follow-up Visit Needed: Yes No

Approx Date Required:

Describe Purpose of Visit:

Specialty:

 Speech

 OT PT

 Nurse Other

Contact:

 Guardian

 Person County/Tribe

 Family Other

Equipment Needed for Follow-up Visit:

Strategies and Assistive Technology Recommendations:

Attachments:

 Strategies Attachment 1

 Strategies Attachment 2

 Photo Page 1

 Photo Page 2

Consultant Signature:

Date Signed:

Time Spent:

Rev

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Attachment: Additional Strategies and Recommendations 1

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Attachment: Additional Strategies and Recommendations 2

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Attachment: Photo Page 1

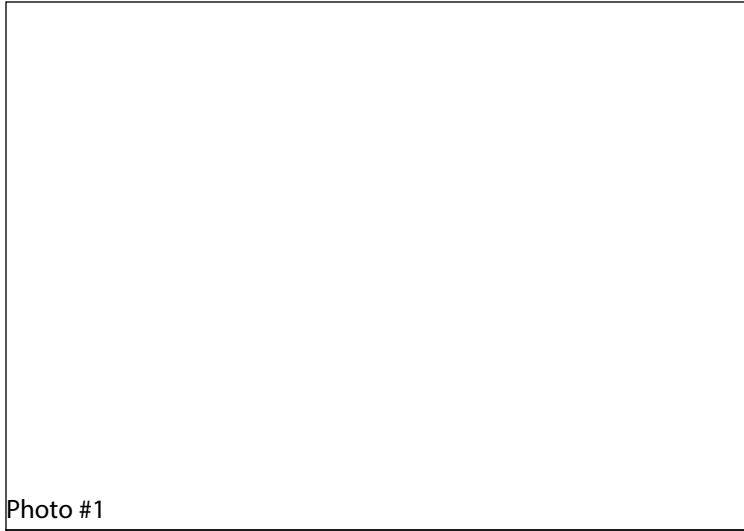


Photo #1

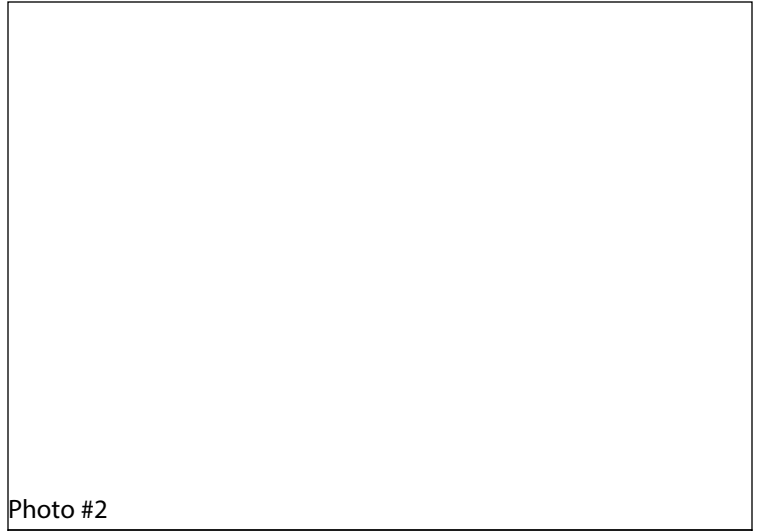


Photo #2

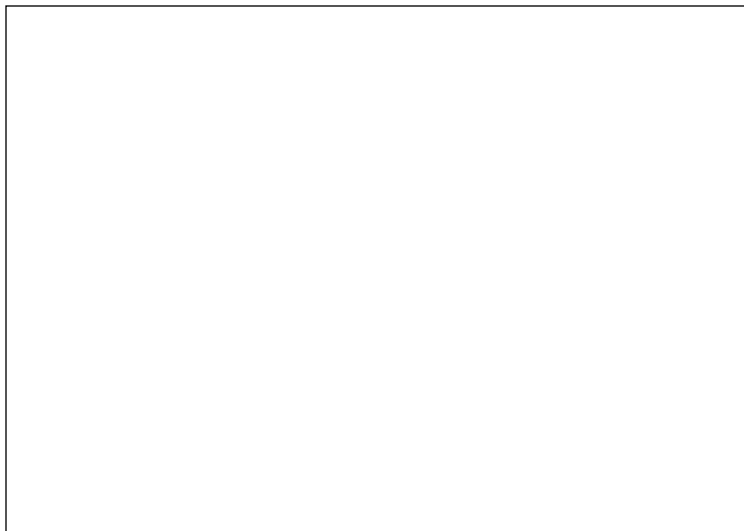


Photo #3

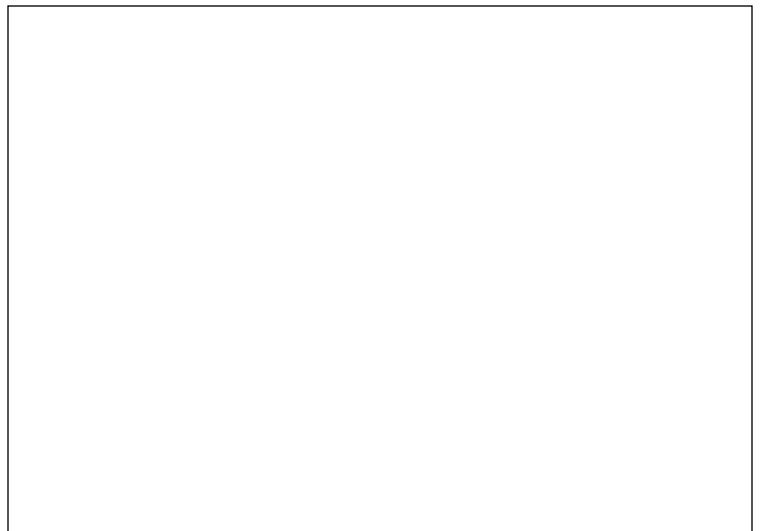


Photo #4

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Attachment: Photo Page 2

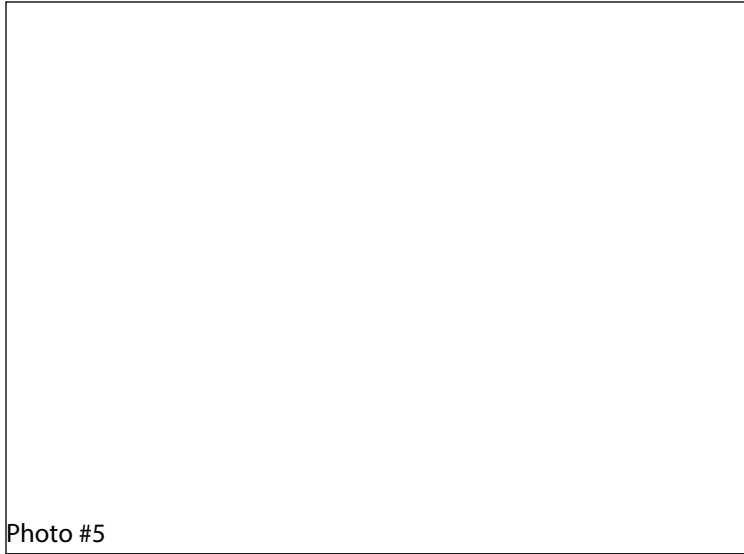


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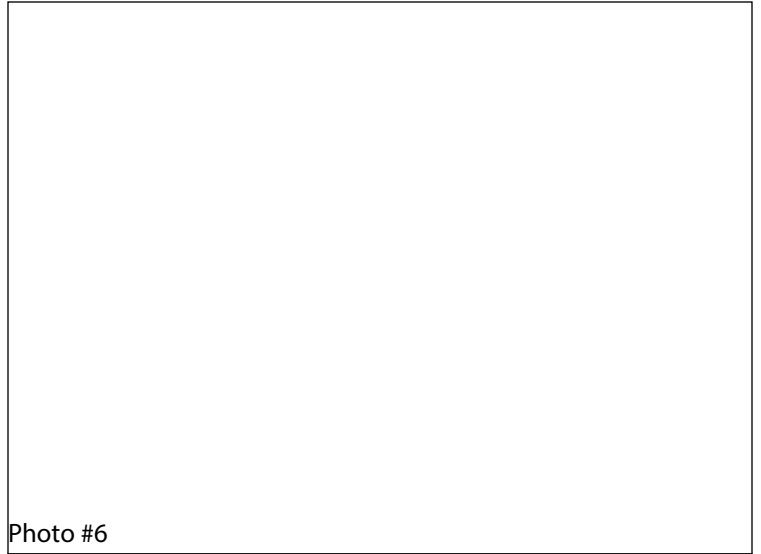


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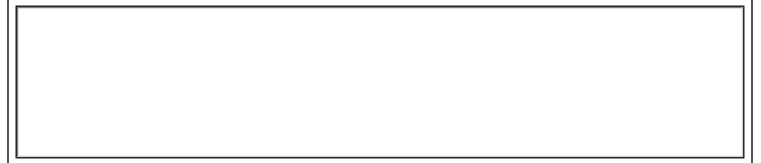


Photo #7

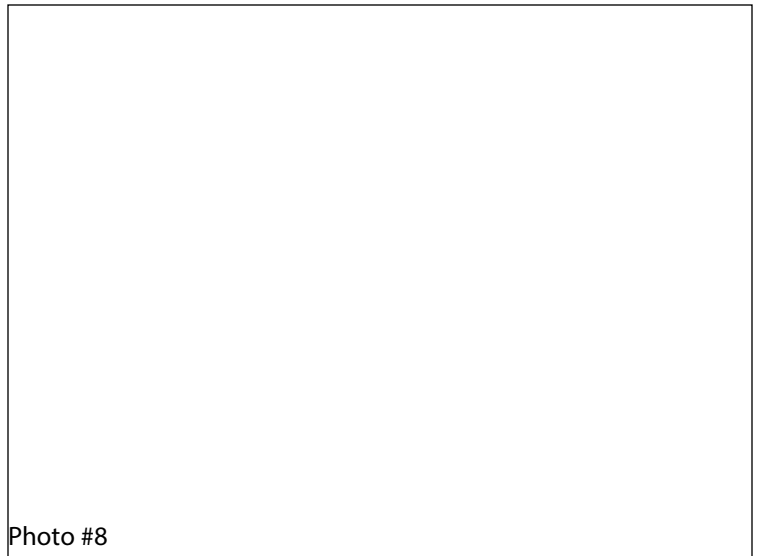
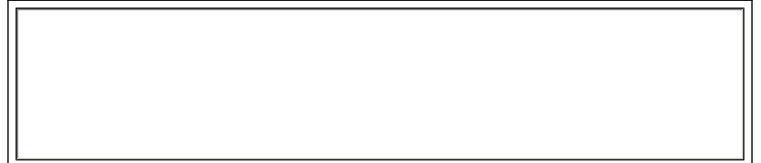


Photo #8



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