

Technology For Home Report

Person ID Number:				Office Use Only	
Visit Date		Visit Time		<input type="radio"/> SR	<input type="radio"/> KP
Referral Date:		Visit #		<input type="radio"/> JH	<input type="radio"/> KR
				<input type="radio"/> Other	
				Received	

AT Goal: _____

AT Activity: Team Visit

Person Contact Information:

DOB: _____

Name: _____

Address: _____

City: _____ Zip: _____

Phone: _____

Email: _____

County/Tribe: _____

Predominant Diagnosis:	ICD-10 code:
_____	_____
Secondary Diagnosis:	ICD-10 code:
_____	_____
_____	_____
_____	_____

Currently In Home Goal to be in own Home

Guardian Contact Information: (Address Same As Above)

Guardian Name: _____

Address: _____

City: _____ Zip: _____

Guardian Phone: _____

Guardian Email: _____

Interpreter Needed: _____

Home Care Service

Home health aide

PDN SN

PCA OT, PT, RT, or ST

County/Tribe Contact ID Number:

Contact Name: _____

Title / Contracted Entity: _____

Phone: _____

Email: _____

Fax: _____

Waiver Service

Brain Injury CAC

DD CADI

AC Elderly Waiver

CDCS

Mental Health Service ARMHS

Other: _____

Person Disabilities / Goals and Special Instruction:

The findings above should be reviewed with any other professionals involved in your care, including your physician, occupational or physical therapist or speech pathologist. While there are many stores which may sell similar products, we recommend that you acquire your equipment from a dealer specializing in assistive technology. We have found that dealers who specialize in assistive technology are able to provide better selection and support than other retailers.

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Pre-visit Info and Equipment Needed:

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:

Follow-up Visit Needed: Yes No Approx Date Required:

Contact: Person Family Guardian County/Tribe Other

Specialty: Speech PT OT Nurse Other

Describe Purpose of Visit:

Equipment Needed for Follow-up Visit:

Immediate Activities:

<input type="checkbox"/> Send report to Person via standard mail	<input type="checkbox"/> Consultant to write letter of Medical Necessity
<input type="checkbox"/> Send report to Person via secure email	<input type="checkbox"/> Consultant to call vendor(s) to schedule bids for installation
<input type="checkbox"/> Consultant to call County/Tribe	<input type="checkbox"/> Office to call vendor(s) to schedule bids for installation
<input type="checkbox"/> Office to call County/Tribe	<input type="checkbox"/> Schedule visit after equipment arrives

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Strategies and Assistive Technology Recommendations:

See Attached Photos

Consultant:	
Consultant Signature:	Date Signed: <input style="background-color: #f4a460;" type="text"/> Time Spent: <input type="text"/> Revised: <input type="text"/>

Additional Consultants involved in this assessment or training:

Consultant:	
Consultant:	
Consultant:	

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Strategies and Recommendations (continued)

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Strategies and Recommendations (continued)

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Attachment: Photo Page 1

Photo #1

Photo #2

Photo #3

Photo #4

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Attachment: Photo Page 2

Photo #5

Photo #6

Photo #7

Photo #8

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Technology for HOME

A Project of MN DHS and LiveLife Therapy Solutions, Inc.

8100 Penn Avenue South, Suite 137, Bloomington, MN, 55437

Office: 952-921-8334 Fax: 952-921-8335 LLTSadmin@livelifetherapysolutions.com



THE THERAPY SOLUTIONS

www.TechnologyforHome.org

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Attachment: Photo Page 3



Photo #9



Photo #10

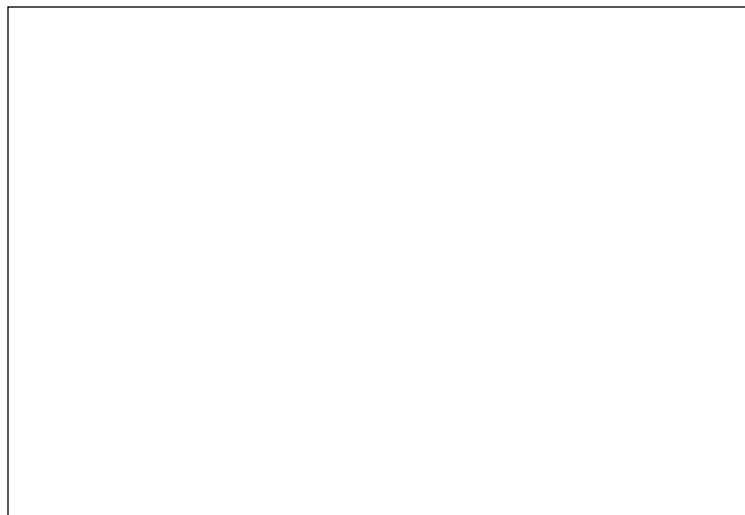


Photo #11

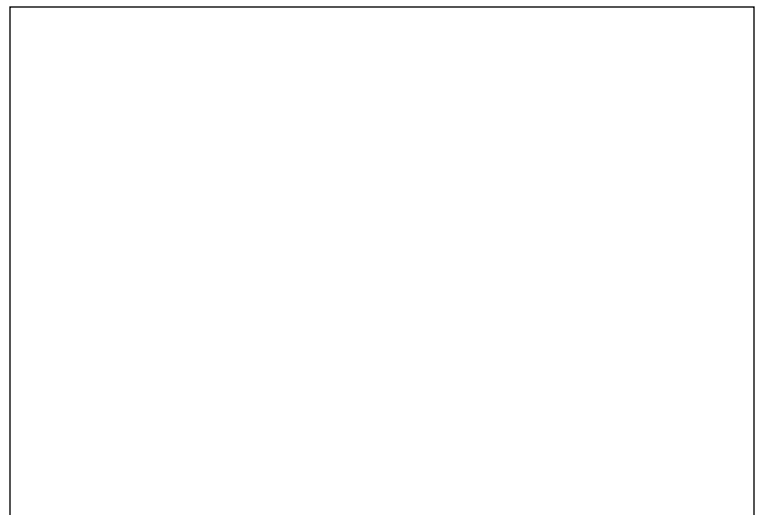


Photo #12



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Attachment: Photo Page 4

Photo #13

Photo #14

Photo #15

Photo #16

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