

Technology For Home Referral Form

Referral Date:

PMI:

Person Making Referral

Name: _____

Phone: _____

DOB:

Name: _____

Address: _____

City: _____ Zip: _____

Phone: _____

Email: _____

County/Tribe: _____

Primary Physician Contact

Clinic: _____

Name: _____

Clinic Address: _____

Phone: _____

Fax: _____

Guardian Contact Information (Address Same As Above)

Guardian Name: _____

Address: _____

City: _____ Zip: _____

Guardian Phone: _____

Guardian Email: _____

Currently In Home Goal to be in own Home

Interpreter Needed:

County/Tribe Contact Information

Contact Name: _____

Title / Contracted Entity: _____

Phone: _____

Email: _____

Fax: _____

Home Care Service Home health aide
 PDN SN
 PCA OT, PT, RT, or ST

Waiver Service
 Brain Injury CAC
 DD CADI
 AC Elderly Waiver
 CDCS

Mental Health Service ARMHS

Other: _____

Person Disabilities / Goals and Special Instruction:

Predominant Diagnosis:	ICD-10 code:
<input type="text"/>	<input type="text"/>

Secondary Diagnosis:	ICD-10 code:
<input type="text"/>	<input type="text"/>

<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>
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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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Person ID Number:		Capability for Remote Assistance	<input type="radio"/> SR	<input type="radio"/> KP
County/Tribe Contact ID Number:			<input type="radio"/> JH	<input type="radio"/> KR
AT Goal:			<input type="radio"/> Other	
AT Activity:			Received	

Next Steps	
<input type="checkbox"/> AAC Screen	Notes:
<input type="checkbox"/> ECU Screen	
<input type="checkbox"/> Not T4H. Referral made to correct service	
Referred to:	

Book for T4H				
<input type="checkbox"/> OT	<input type="checkbox"/> PT	<input type="checkbox"/> SLP	<input type="checkbox"/> ATP	<input type="checkbox"/> Team visit required

Pre-visit Info and Equipment Needed:	

Location of Consultation:	<input type="checkbox"/> Home	<input type="checkbox"/> Work Place	<input type="checkbox"/> Cnty/Tribal Office	Other:
	<input type="checkbox"/> E-mail	<input type="checkbox"/> Video Conf	<input type="checkbox"/> Phone	

Steps and responsibilities in process discussed with Referrer: Assessment, Equipment, Training, etc.

Comments Regarding Calls, E-Mail, Follow up

Policies Reviewed with Person:					
<input type="checkbox"/> Admission Criteria	<input type="checkbox"/> Grievance Policy	<input type="checkbox"/> Notice of Privacy Practices			
<input type="checkbox"/> Service Termination/Suspension Policies	<input type="checkbox"/> Positive Supports Plan	<input type="checkbox"/> Mandatory Reporting Policy			

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