

Rehab Technology Center

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Rehab Technology Center **Program Referral**

Patient Information	
Name:	Medical Records No
Date of Birth:	
Address:	
City/County/State/Zip	
	Phone/Work: ()
	Secondary Diagnosis: Referral Source:
School:	
Specific Information	
Equipment Goals:	
Current Wheelchair:	
Communication System:	
Currently using any switches?	
Services	
OrthoSEAT	Computer Access
☐ Wheelchair Mobility Evaluation – Custom	☐ Computer Access Evaluation
Seating & Wheelchair Modifications (Peds. & Adults)	
☐ Pressure Monitor Evaluation	Augmentative Communication
☐ Custom Equipment Evaluation	Augmentative Communication Therapeutic / Equipment Evaluation
Assistive Technology Services	
☐ Childcare Equipment Evaluation / Fabrication	
□ Environmental Control Evaluation (Electronic Aids to Da	aily Living)
☐ Emergency Call Systems / Telephone Access	, 3,
☐ A.T. for Memory and Organization Tasks	
Physician Prescription	
Prescription:	
Physician Name:	
Address:	
Signature:	Date: