Department of Intellectual & Developmental Disabilities | Seating & Positioning Clinics

INTAKE FORM

We need the following information on file in order for a patient to be seen by our Physical or Occupational Therapists.

- ☐ Intake form
- ☐ Physician Referral form
- ☐ Consent
- ☐ Copies of all medical insurance cards (fronts and backs)

Once this documentation is on file with our clinic, it is valid for one year but we need to be notified of any changes. All forms are PDF fillable and can be found on our website http://tn.gov/didd/seating/referrals.

REASON FOR VISIT			
Please describe in detail what the patient's seating and/or positioning needs are:			
PATIENT INFORMATION			
Legal Last Name:	Legal First Name:	Middle Initial:	Name Patient Goes By:
Street Address:	City:	State:	Zip:
SS#:	Date of Birth:	Gender: ☐ Female ☐ Male	
Ethnicity: ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ White or Caucasian ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic/Latino ☐ Not Reported			
PLEASE SELECT ONE: ☐ DIDD Waiver ☐ ECF CHOICES ☐ State ICF-IDD Home ☐ Private ICF-IDD ☐ N/A			
PATIENT TEAM CONTACT INFORMATION			
Scheduling Contact's Name:	Relationship to Patient:		
Phone:	Email:		
Support Agency (if applicable):	Phone:	Email:	
ISC/Case Manager (if applicable):	Phone:	Email:	
Legal Guardian/Conservator (if applicable):	Phone:	Email:	
Primary Care Physician:	Phone:	Fax:	

INSURANCE INFORMATION

PLEASE PROVIDE FRONT AND BACK COPIES OF INSURANCE CARDS

Name of Primary Insurance Company:	Policy Holder Relation to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other
ID Number:	
Name of Secondary Insurance Company:	Policy Holder Relation to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other
ID Number:	

If the policy holder is not the patient, please complete the following section:

Policy Holder's Name:			Phone:
Street Address:	City:	State:	Zip:
SS#:		Date of Birth (mm-dd-yyyy):	

OTHER THERAPY SERVICES

Is patient receiving Home Health services for any reason? ☐ Yes ☐ No

Home Health Agency's Name:	Phone:	Email:

Is patient receiving any other therapy services? ☐ Yes ☐ No

Physical Therapist's Name:	Phone:	Email:
Occupational Therapist's Name:	Phone:	Email:
Speech Therapist's Name:	Phone:	Email:

HEALTH INFORMATION

Please check if the patient has any of the following:

☐ Arthritis	☐ Heart disease	☐ Recent falls
☐ Aspiration pneumonia	☐ High blood pressure	☐ Recent fractures
☐ Cerebral palsy	☐ Intellectual/developmental disability	☐ Seizures
☐ Constipation	☐ Multiple Sclerosis	☐ Spina bifida
☐ Dementia	☐ Muscular dystrophy	☐ Stroke
☐ Diabetes	☐ Osteoporosis/osteopenia	☐ Traumatic brain injury
☐ Dysphagia	☐ Parkinson's disease	☐ Other:
☐ Gastroesophageal Reflux Disease	☐ Polio/post-polio	☐ Other:

Has the patient had any surgeries or hospitalizations in the last year: ☐ Yes ☐ No	Does the patient have current and/or a history of skin breakdown: ☐ Yes ☐ No

Height:	Weight:	**PLEASE PROVIDE A LIST OF MEDICATIONS THE PATIENT IS CURRENTLY TAKING**

FORM COMPLETION

Completed By:	Phone:	Date:

* Please note that we are unable to process any requests if all of the required information is not provided. Thank you for fully completing this form. We look forward to serving the needs of this patient. *

CLINIC LOCATIONS AND CONTACT INFORMATION

West TN Clinic
Phone: (901) 745-7509
Fax: (615) 770-7568
wtrc.seating.positioning@tn.gov

Middle TN Clinic
Phone: (615) 231-5147
Fax: (615) 886-9972
mtrc.referrals@tn.gov

East TN Clinic
Phone: (423) 787-6689
Fax: (615) 401-6801
etrc.referrals@tn.gov