Department of Intellectual & Developmental Disabilities | Seating & Positioning Clinics

NEW PATIENT
INTAKE AND MEDICAL HISTORY FORM

Instructions for completing this form:

1. This form must be completed in its entirety before an appointment for an evaluation can be scheduled.
2. Pictures of all insurances cards (front and back) need to be attached.
3. Send this form, copy of insurance cards, the Consent for Seating and Positioning Services form, and the Seating and Positioning Physician Referral form to the clinic in order to schedule an evaluation.

IMPORTANT: Is patient receiving Home Health Care for any reason? ☐ Yes ☐ No If yes, what company?_____

PLEASE SELECT ONE: ☐ DIDD Waiver ☐ ECF Waiver ☐ State ICF/IID ☐ Private ICF/IID ☐ Dept. Children's Services ☐ N/A

REASON FOR REFERRAL			
PATIENT INFORMATION			
Last Name:	First Name:	Middle Name:	SS#: - -
Street Address:		City:	State: Zip:
Date Form Completed:	Date of Birth (mm-dd-yyyy):	Gender: ☐ Female ☐ Male	
CONTACT INFORMATION			
Contact Person Name (for scheduling):	Contact Person Phone:	Relationship to Patient:	
Supporting Agency (if applicable):	Agency Phone:		
Independent Support Coordinator or Case Manager:		Phone:	
PHYSICIAN INFORMATION			
Referring Physician Name:	Phone:	Fax:	
Primary Care Physician (if different):	Phone:	Fax:	
PRIMARY INSURANCE INFORMATION			
Name of Insurance Company:	ID Number:	Group Number:	
Policy Holder Name:	Policy Holder Date of Birth:	Policy Holder SS#: - -	
Insurance Company Phone Number:	Policy Holder Relation to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other		
SECONDARY INSURANCE INFORMATION			
Name of Insurance Company:	ID Number:	Group Number:	
Policy Holder Name:	Policy Holder Date of Birth:	Policy Holder SS#: - -	
Insurance Company Phone Number:	Policy Holder Relation to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other		

OTHER SERVICES

Is patient receiving any other therapy services? ☐ Yes ☐ No If yes, what type? ☐ OT ☐ PT ☐ SLP

Therapist(s) contact information:

MEDICAL CONDITIONS

Please check if you have any of the following (or attach a list):

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

Please check any medical equipment you use:

- ☐ Ceiling lift
- ☐ CPAP/BiPAP machine
- ☐ G-tube/J-tube/G-J tube
- ☐ Mechanical floor lift
- ☐ Shower/bath chair or bench
- ☐ Tracheostomy
- ☐ Other:
- ☐ Other:

Do any of your medical issues interfere with your ability to complete your daily activities/routine? ☐ Yes ☐ No
If yes, please explain:

OTHER MEDICAL ISSUES

Have you had any hospitalizations in the past year?
☐ Yes ☐ No Type(s) and Date(s):

Have you had any surgeries in the past year?
☐ Yes ☐ No Type(s) and Date(s):

Please list any medications you are presently taking (or attach a list):

Height:

Weight:

Do you have a history of pressure injuries (skin breakdown)? If so, please explain:

WHEELCHAIR AND POSITIONING EQUIPMENT INFORMATION

Please indicate equipment you <u>currently</u> have:

- ☐ Bed positioning
- ☐ Communication device
- ☐ Custom Dining chair
- ☐ Hospital bed
- ☐ Mobile bed positioning (CIS)
- ☐ Prone on forearms
- ☐ Quadruped on forearms
- ☐ Recliner
- ☐ Sidelyer
- ☐ Stander
- ☐ Tall kneeler
- ☐ Wheelchair, manual
- ☐ Wheelchair, power
- ☐ Other:
- ☐ Other:

Does any of your equipment interfere with your ability to complete your daily activities/routine? ☐ Yes ☐ No
If yes, please explain:

WHEELCHAIR AND POSITIONING EQUIPMENT INFORMATION (CONT'D)
Do you have a current durable medical equipment (DME) vendor who provided you with and/or repairs your wheelchair or other equipment? ☐ Yes ☐ No If yes, what is the name of the company? Would you like to continue to use the same vendor, if possible? ☐ Yes ☐ No
Can your wheelchair fit everywhere you need it to go? ☐ Yes ☐ No ☐ N/A (I do not have a wheelchair) If no, please explain:
OUTCOMES FOR APPOINTMENT
What outcomes would you like to see as a result from this appointment?

Form Completed By:	**Contact number:**	**Date Completed:**

CLINIC LOCATIONS AND CONTACT INFORMATION:

West TN Clinic
Phone: (901) 745-7509
Fax: (901) 745-7742
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: (423) 798-6220
ETRC.Referrals@tn.gov