

SEATING AND POSITIONING PHYSICIAN REFERRAL

Please fully complete the following information and provide a copy of the patient's most recent progress/chart note.

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

PHYSICIAN INFORMATION

Physician Name: _____ NPI#: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

PHYSICIAN REFERRAL

The above person is being referred to the DIDD Seating and Positioning Clinic for Occupational Therapy (OT) or Physical Therapy (PT) evaluation and treatment of wheelchair seating and/or positioning needs.

Relevant Diagnoses **including** ICD-10 Codes:

Comments/Precautions: _____

Physician Signature: _____ Date: _____

*** Please provide a copy of the patient's most recent progress/chart note. ***

CLINIC LOCATIONS AND CONTACT INFORMATION

West TN Clinic
Phone: (901) 745-7509
Fax: (901) 745-7742
wtrc.seating.positioning@tn.gov

Website: <http://tn.gov/didd/seating>

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

Forms Resource: <http://tn.gov/didd/seating/referrals>

East TN Clinic
Phone: (423) 787-6689
Fax: (423) 798-6220
etrc.referrals@tn.gov