

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: tn.gov/disability-and-aging

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: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Ethnicity: <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Reported			
PLEASE SELECT ONE: <input type="checkbox"/> DDA Waiver <input type="checkbox"/> ECF CHOICES <input type="checkbox"/> State ICF-IDD Home <input type="checkbox"/> Private ICF-IDD <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other	
ID Number:			
Name of Secondary Insurance Company:		Policy Holder Relation to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Home Health Agency's Name:		Phone:	Email:
Is patient receiving any other therapy services? <input type="checkbox"/> Yes <input type="checkbox"/> 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:			
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Recent falls	
<input type="checkbox"/> Aspiration pneumonia	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Recent fractures	
<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Intellectual/developmental disability	<input type="checkbox"/> Seizures	
<input type="checkbox"/> Constipation	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spina bifida	
<input type="checkbox"/> Dementia	<input type="checkbox"/> Muscular dystrophy	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoporosis/osteopenia	<input type="checkbox"/> Traumatic brain injury	
<input type="checkbox"/> Dysphagia	<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Other:	
<input type="checkbox"/> Gastroesophageal Reflux Disease	<input type="checkbox"/> Polio/post-polio	<input type="checkbox"/> Other:	
Has the patient had any surgeries or hospitalizations in the last year: <input type="checkbox"/> Yes <input type="checkbox"/> No		Does the patient have current and/or a history of skin breakdown: <input type="checkbox"/> Yes <input type="checkbox"/> 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