

## SEATING & POSITIONING REPAIR REQUEST

This referral form is to be used only for repairs to equipment fabricated by the Seating and Positioning Clinics. Repairs for other equipment should be referred to a durable medical equipment vendor. Individuals may need to be referred through the clinic for an evaluation before repairs can be completed. Please see the Intake Forms Outline for additional information.

PLEASE SELECT ONE:

DIDD Waiver     ECF Waiver     State ICF Home     Private ICF/IID     N/A

NAME: \_\_\_\_\_ DATE OF REQUEST: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

SUPPORTING AGENCY (if applicable): \_\_\_\_\_

SCHEDULING CONTACT INFORMATION:

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

OCCUPATIONAL / PHYSICAL THERAPIST (if applicable):

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

PLEASE DESCRIBE REPAIR NEEDS IN DETAIL:

FORM COMPLETED BY:

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ DATE: \_\_\_\_\_

**West TN Clinic**

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