Shepherd Center

Center for Assistive Technologies AT Referral Form

Please complete the below sections, including the diagnosis and sign.
Please attach the most recent medical history and physical or chart note.
(Not completing the form/providing chart note may delay scheduling)

Client Information

Name: _____ Date of Birth:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

☑ OT and/or SLP Evaluation and Treatment for Assistive Technology Services

Diagnosis and/or ICD-10 Code (required): _____

Insurance Type: ☐ Medicare ☐ Medicaid ☐ Private Insurance: _____

☐ VR ☐ VA

Access Technology Lab – check all that apply:

☐ Environmental Controls ☐ Personal Device Access ☐ Adaptive Gaming

☐ Device Mounting ☐ Cognitive Supports

Referral Source

Provider Name: _____ Phone: _____

Fax: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Provider Signature: _____ Date: _____

Appointment will not be scheduled without signature.

Have this form faxed to 404-350-7356. If you are not contacted by scheduling after **two business days**, please call 404-355-1144.