



DEPARTMENT OF
INTELLECTUAL AND
DEVELOPMENTAL DISABILITIES

SEATING AND POSITIONING CLINIC REFERRAL

West TN Clinic

Phone: (901) 745-7509

Fax: (901) 745-7742

[Email](#)

Middle TN Clinic

Phone: (615) 231-5147

Fax: (615) 886-9972

[Email](#)

East TN Clinic

Phone: (423) 787-6689

Fax: (423) 798-6220

[Email](#)

PLEASE SELECT ONE: DIDD Waiver ECF Waiver State ICF/IID Private ICF/IID Other

PHYSICIAN ORDERS:

We require a physician's order to provide services. The order needs to be less than one year old and should state, "Seating and Positioning Clinic to evaluate and treat for wheelchair, positioning equipment, and/or repairs." Please include with this form.

INSURANCE: Please attach copies of the front and back of all current medical insurance cards and send in with your paperwork.

Name: _____ Date of Referral: _____

Social Security Number _____ Date of Birth: _____

Mailing Address _____ Phone: _____

Supporting Agency: _____

CONTACT INFORMATION (for scheduling)

Name: _____ Phone: _____ Email: _____

PRIMARY CARE PHYSICIAN (PCP)

Name: _____ Phone: _____ Fax: _____

INDEPENDENT SUPPORT COORDINATOR / CASE MANAGER (if has one)

Name: _____ Phone: _____ Email: _____

OCCUPATIONAL THERAPIST (if has one)

Name: _____ Phone: _____ Email: _____

PHYSICAL THERAPIST (if has one)

Name: _____ Phone: _____ Email: _____

Repair Evaluation Other (Explain): _____

DESCRIBE THE REPAIR / EVALUATION NEEDED:

DIAGNOSES (may attach list if available) :

CURRENT MEDICATIONS (may attach list if available) :

OFFICE USE ONLY	See TIMS for Notes
COMMENTS:	COMPLETED BY: