



Visit #:

**ASSISTIVE TECHNOLOGY
PRE-EVALUATION SURVEY**

Patient: Last _____ First _____ MI _____ DOB: _____ Gender M F

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Other Phone: _____

Parent/Guardian: _____

Marital Status M S D W Birth State: _____ Religion: _____ Race: _____

SSN# _____ Primary Care Physician: _____

Who referred you for this evaluation _____

Emergency Contact

Name: _____ Phone: _____

Address: _____ Relationship patient: _____

Guarantor/Insurance Subscriber (IF OTHER THAN PATIENT)

Name: _____ Phone: _____

Address: _____ Relationship to patient: _____

SSN: _____ DOB: _____

Place of

Employment: _____ City: _____ State: _____ Zip: _____

Employment Phone Number: _____

Primary Insurance Information

Insurance Co: _____ Policy # _____

Claims Address: _____ Provider Phone #: _____

Secondary Insurance Information

Insurance Co: _____ Policy # _____

Claims Address: _____ Provider Phone #: _____

SIGNIFICANT MEDICAL HISTORY

CURRENT DIAGNOSIS: _____

DATE OF ONSET: _____



Mizzou Therapy Services
University of Missouri Health Care

REASON FOR ASSESSMENT

(If you need more space, attach continued information.)

Communicaton Device (patient does not talk, talks very little or is difficult to understand)

Can the patient point or reach out and touch?

Written Communication assistance (patient has difficulty handwriting, typing, spelling or organizing written work)

Describe how client currently completes written work

Other (Please explain)

EDUCATION BACKGROUND

Highest Grade level completed in school

Can the client read functionally? YES NO

Can the client write or type adequately? YES NO

Name of school or workplace:

Is travel required to site? Y N Contact

Currently receiving Speechtherapy Occupational therapy Physical therapy

Where:

PERSON COMPLETING THIS FORM :

RELATIONSHIP TO CLIENT:

PHONE:

PLEASE SEND THE COMPLETED SURVEY WITH THE PHYSICIAN'S ORDER TO:

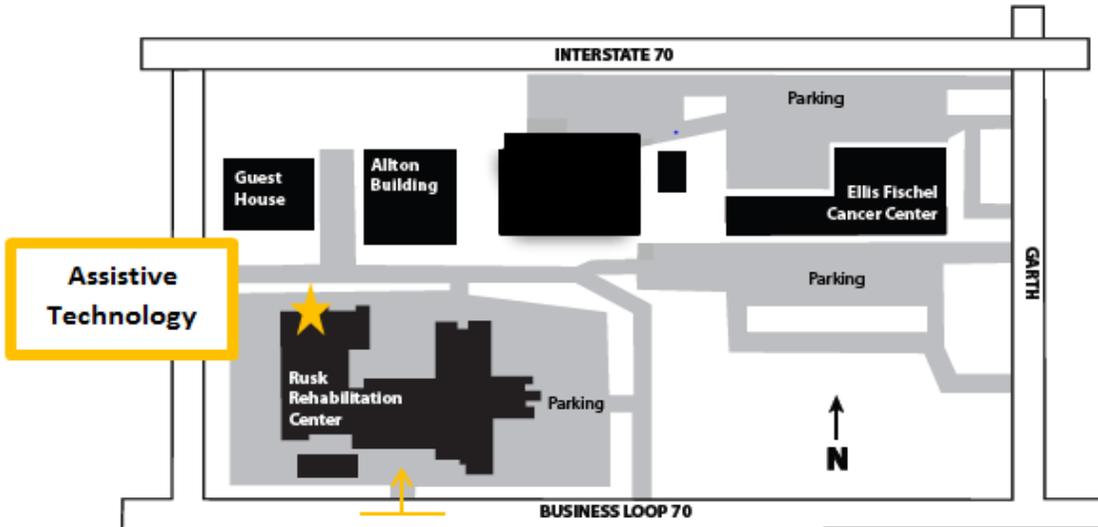
THE ASSISTIVE TECHNOLOGY EVALUATION CENTER
MIZZOU THERAPY SERVICES
315 BUSINESS LOOP I-70 WEST
COLUMBIA, MO 65203

OR FAX TO: (573) 884-9677

WHEN WE RECEIVE THE COMPLETED SURVEY AND PHYSICIAN'S ORDER
WE WILL CONTACT YOU TO SET UP A TIME TO BEGIN THE EVALUATION. IF YOU SHOULD
HAVE ANY QUESTIONS ABOUT THIS SURVEY, PLEASE FEEL FREE TO CONTACT US AT (573)
884-2642.



Mizzou Therapy Services
University of Missouri Health Care



Directions from North (Moberly), East (St. Louis), South (Jefferson City) of Columbia

1. Take I-70 West to the Providence Road exit.
2. Turn left onto Providence Road.
3. Turn right onto Business Loop 70.
4. Turn right at the 2nd Rusk Rehabilitation entrance and turn left into the parking area. Travel north along side building.
5. Entrance "C".

Directions from West of Columbia (Kansas City)

1. Take I-70 East to the Providence Road exit.
2. Turn right onto Providence Road.
3. Turn right onto Business Loop 70.
4. Turn right at the 2nd Rusk Rehabilitation entrance and turn left into the parking area. Travel north along side building.
5. Entrance "C".

Questions: 573-882-2642

Mizzou Therapy Services
315 Business Loop 70, Columbia, MO 65203



Physician Prescription

Patient Information

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____

Clinical Information (Please check both a medical and secondary diagnosis)

Medical Diagnosis:

___ Cerebral Palsy ___ Autism ___ Mental Retardation

___ Cerebral Vascular Accident (CVA) ___ Traumatic Brain Injury(TBI)

___ Amyotrophic Lateral Sclerosis (ALS) ___ Muscular Dystrophy (MD)

___ Spinal Cord Injury (SCI) ___ Multiple Sclerosis (MS) ___ Deafness

Other _____ (Please write in diagnosis)

Secondary Diagnosis:

___ Speech Disturbance ___ Aphasia ___ Ataxia ___ Quadriplegic

___ Flaccid Hemiplegia ___ Spastic Hemiplegia ___ Paraplegia

___ Friedreich's Ataxia ___ Developmental Aphasia

Other _____ (Please write in diagnosis)

Procedure Prescribed

___ Augmentative Communication Evaluation to be completed within 6 months and device as recommended.

___ Occupational Therapy Evaluation and Treatment

___ Speech/Occupational Therapy evaluation for written communication to be completed within 6 months.

Physician Information

Physician's Name (print) _____

Phone #: _____

Address: _____

Physician's Signature: _____ Date: _____ Time: _____