Center for Inclusive Design and Engineering (CIDE)
COLLEGE OF ENGINEERING, DESIGN AND COMPUTING
UNIVERSITY OF COLORADO **DENVER | ANSCHUTZ MEDICAL CAMPUS**
Breaking Barriers | Changing Lives

Please Fax or Email Completed Form to:
303-315-1270 (Fax)
cide-clinic@UCDenver.edu

Center for Inclusive Design and Engineering (CIDE) Clinic Referral & Intake Form | Date form completed:_____

REFERRAL FOR:

- ☐ Wheelchair Seating/Mobility Assessment
- ☐ Nighttime Positioning/Posture Management
- ☐ Motor Access to Technology (Switch Access)
- ☐ Augmentative/Alternative Communication (AAC)
- ☐ Computer Access
- ☐ Electronic Aids to Daily Living/Home Automation
- ☐ Worksite Accommodation/Ergonomics
- ☐ Learning/Cognitive Aids
- ☐ Other: _____

If referral is for wheelchair assessment or training, please indicate:

Name of Wheelchair Supply Company: _____

Name of specialist you are working with: _____

Is Disability Result of an Accident or Injury:
☐ Yes, **Date:** _____ ☐ No

Form Completed by: _____

Referred by: _____

Phone: _____

Client seen at CIDE before?
☒ **Yes** ☐ **No**

Reason for Referral/ Primary problem to be addressed:

_____

_____

_____

CLIENT INFORMATION

Client Name: _____ **Date of Birth**: _____ **1°Diagnosis:** _____

Address: _____ **2°Diagnoses:** _____

Primary Contact for scheduling appointments: _____

Phone (home): _____ **(cell):** _____ **(work):** _____

Email: _____

Does client live in a SNF/Nursing Home? ☐YES ☐NO **Is client receiving in-home nursing services?** ☐YES ☐NO

(NOTE: If answer to either of the above questions is yes, we cannot bill medical insurance for our services)

MEDICAL INSURANCE / OTHER PAYER INFORMATION

Primary Insurance: _____
Policy Holder: _____
ID # _____
Phone# _____
Other Funding Source Name: _____

Secondary Insurance: _____
Policy Holder: _____
ID # _____
Phone# _____
Funding Source Contact & Phone #: _____

PHYSICIAN INFO: Name of physician you have seen recently from whom we may request a script/referral for our services

Physician: _____ **Phone:** _____ **Fax:** _____

CLIENT ACKNOWLEDGMENT AND AUTHORIZATION (please read to client over phone)

I understand that I am being referred for a clinical assessment by a PT, OT or ST specialist from the Center for Inclusive Design and Engineering (CIDE) in order to help determine the equipment/device that will best meet my needs. I understand that CIDE, through CU Medicine, will bill my health insurance provider for these services under my PT,OT or ST benefits, and that I am responsible for understanding my coverage for therapy services. I authorize CIDE to contact my physician on my behalf to request a referral, and to contact my insurance carrier to verify insurance coverage for these services.

_____ _____ _____
Client's Name or Representative **Authorizing Signature** **Date**

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OTHER THERAPIST INFORMATION

Please detail any therapy services the client is receiving from other providers.

☐ **Speech Therapy:**

Name: _____ Practice: _____

Phone: _____ Day Seen (Circle): Mon Tues Wed Thurs Fri Sat Sun

Name: _____ Practice: _____

Phone: _____ Day Seen (Circle): Mon Tues Wed Thurs Fri Sat Sun

☐ **Occupational Therapy:**

Name: _____ Practice: _____

Phone: _____ Day Seen (Circle): Mon Tues Wed Thurs Fri Sat Sun

☐ **Physical Therapy:**

Name: _____ Practice: _____

Phone: _____ Day Seen (Circle): Mon Tues Wed Thurs Fri Sat Sun

☐ By checking this box you acknowledge that we are able to contact any of the therapists listed above to insure a coordination of services.

_____ _____ _____

Client's Name or Representative **Authorizing Signature** **Date**