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:
303-573-2340 (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(s) Seen: Mon Tues Wed Thurs Fri Sat Sun

Name: ______________________________ Practice: ____________________________________

Phone: ______________________

Day(s) Seen: Mon Tues Wed Thurs Fri Sat Sun

☐ **Occupational Therapy:**

Name: ______________________________ Practice: ____________________________________

Phone: ______________________

Day(s) Seen: Mon Tues Wed Thurs Fri Sat Sun

☐ **Physical Therapy:**

Name: ______________________________ Practice: ____________________________________

Phone: ______________________

Day(s) Seen: 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 ensure a coordination of services.

________________________ ____________________________ ________________

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