Wheelchair/Seating Evaluation Referral Form

Patient Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell _____ Date of Birth _____

Social Security Number _____

Date of Last Appointment _____

Primary Insurance _____

_____

Secondary Insurance _____

_____

Prescription

☐ Check here to prescribe a physical therapy evaluation that will include an evaluation of wheelchair and seating needs and provide follow-up.

Physician Signature _____

Date _____ UPIN _____

Medicaid Provider Number _____

Please **fax** referral form along with patient progress note to **601-936-8842. Progress note must include why patient needs mobility assessment,** i.e. history of falls or balance impairments.

Earl R. Wilson, Founding Chairman

METHODIST REHABILITATION CENTER