MountainCare
CARING FOR OUR WNC NEIGHBORS

Seating and Wheeled Mobility Clinic Phone 828-820-2828
Return by email <BarbaraC@mtncare.org> or FAX 828-277-4855

REFERRAL FORM

For office use only MTC ID #_____ Physicians – please send clinical notes with referral form

Referred By (name, credentials and phone number):_____

Client's Full Name: ___ _____ Preferred Name: _____

Birth date: _____ Male _____Female_____ Marital Status: _____

Address: _____County: _____

Telephone:_____

Client and/or Caregiver E-mail Address: _____

Living with whom: _____ Relationship_____

Please list one other person's contact name and number(s):

Is this person a Primary caregiver? Yes No

1) Name: _____Relationship: _____

Address_____

Home phone: _____Business phone: _____ Cell/Beeper#_____

Insurance Company: _____

*Policy Number:*_____

Primary Care Physician and phone number: _____

Diagnosis: _____

Reason for referral: _____

Do you have a current pressure injury? Yes No

What is the location, size and stage of this wound? _____

Do you have a preferred Supplier for your wheelchair needs? Yes No

If so, who is the supplier that you work with: _____

Available days for appointment: Mon. Tues. Wed. Thurs. Fri. *(Circle days that apply)*