

# UCP *No Boundaries* Assistive Technology Center REFERRAL FORM

(Please Print)

Today's date:			Person making referral:			
<b>PATIENT INFORMATION</b>						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Diagnosis:	Date of diagnosis: / /	Email address:		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social security #:		Home phone #: ( )	
City:	State:		ZIP code:		Alternate phone #:	
Occupation:	Employer:			Employer phone #: ( )		
Place of residence:						
<input type="checkbox"/> Home		<input type="checkbox"/> Nursing Home		<input type="checkbox"/> In-home Hospice Care		
<input type="checkbox"/> Assisted Living Facility		<input type="checkbox"/> Group Home		<input type="checkbox"/> Rehabilitation Facility		
<input type="checkbox"/> Hospital		<input type="checkbox"/> Hospice				
<b>REASON FOR REFERRAL</b>						
Name of person making referral:		Relationship to patient:	Address (if different):		Phone #: ( )	
Type of Referral: <input type="checkbox"/> Communication Assessment <input type="checkbox"/> Communication Therapy – Name of device: _____						
<input type="checkbox"/> Computer Access Assessment <input type="checkbox"/> Computer Access Training – Name of Products: _____						
<input type="checkbox"/> Speech & Language Assessment <input type="checkbox"/> Speech & Language Therapy						
Please describe reason for assessment/therapy:						
Patient is <b>unable</b> to: <input type="checkbox"/> Talk <input type="checkbox"/> Talk Clearly <input type="checkbox"/> Read/Spell <input type="checkbox"/> Handwrite <input type="checkbox"/> Walk <input type="checkbox"/> Use Hands <input type="checkbox"/> Identify Pictures						
<b>PHYSICIAN INFORMATION</b>						
Name of primary care physician:						
Street address:			Suite #:		Phone #:	
City:	State:		ZIP code:		Fax #:	
UPIN #:	NPI #:		Medical assistance 9 digit provider #:			

**INSURANCE INFORMATION**

**Please note: UCP *No Boundaries* Assistive Technology Center does not accept Insurance, Medicare, or Medical Assistance as forms of payment for assessments, therapy, or training. Information below should be completed for patients receiving a Communication Device Assessment to assist in procurement of the communication device:**

Is this patient covered by insurance?     Yes     No

Please indicate primary insurance

Insurance    Name of company: \_\_\_\_\_  
 Medicare  
 Medical Assistance  
 Managed Care Organization:    Name of company: \_\_\_\_\_  
 Other: \_\_\_\_\_

Subscriber's name:	Subscriber's S.S. #:	Birth date:	Group #:	Policy #:	Co-payment:
		/ /			\$

Patient's relationship to subscriber:     Self     Spouse     Child     Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:
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Patient's relationship to subscriber:     Self     Spouse     Child

**\*\* If patient is receiving an assessment for a Communication Device, please provide a copy of the front and back of the patient's insurance cards to UCP Staff on the day of the assessment\*\***

Other

**PAYMENT INFORMATION**

Method of payment for assessment/therapy/training:     Check     Cash

**FEE SCHEDULE**

Fees for services are listed below. Payment may be made on the day of service or, for your convenience, an invoice can be mailed following provision of services:

Pay on day of service     Please invoice

Fees:

Augmentative and Alternative Communication Assessment	\$300.00
Assistive Technology/Computer Access Assessment	\$300.00
Speech & Language Assessment	\$200.00
Augmentative and Alternative Communication Set-up/Therapy/Training	\$80.00 per hour
Assistive Technology/Computer Access Set-up/Therapy/Training	\$80.00 per hour
Speech & Language Therapy	\$70.00 per hour
Travel fees for any service occurring outside of UCP's main office:	\$35.00 per hour

Interested in:     Office appointment     In-home appointment

***Please return this completed form to UCP No Boundaries Assistive Technology Center by:***

**Mail:**    UCP *No Boundaries* Assistive Technology Center  
 1700 Reisterstown Road, Suite 226  
 Baltimore, MD 21208  
 410-484-4540 ext. 4084

**Fax:**    410-484-0831    Attn: Angela Strauch

**Email:** [astrauch@ucp-cm.org](mailto:astrauch@ucp-cm.org)

*Once your referral form has been completed, you will be contacted to schedule an appointment. Thank you.*

