EVALUATION QUESTIONNAIRE

Date:____________________________ Client Name:______________________________
Caller:____________________________ Contact Phone:___________________________
Caller's Relationship to Client:____

1. What equipment is being requested?____
____
____

2. Who is to be involved in the evaluation:
Name _____________________________ Phone ____________________________
Name _____________________________ Phone ____________________________
Name _____________________________ Phone ____________________________

3. Date of Birth ______________________________
4. Diagnosis ____
5. School or Daily Location ____

6. Dates and Times for the Evaluation:
Date:____________________ Time:_____________________
Date:____________________ Time:_____________________
Date:____________________ Time:_____________________

7. Where is the evaluation to take place:
Facility____
Directions____
____
____
____

8. What is the client's funding (check all that apply):
______ Medicaid #________________________________
______ Medicare #________________________________
______ Private Insurance, specify:____
______ CAP MR Name:_________________________ Phone: ________________________
______ CAP C Name: __________________________ Phone: _________________________

9. Special comments and instructions:____
____
____
____
____

Prepared by:_____________________