PACE ASSISTIVE TECHNOLOGY SERVICES LLC

REFERRAL FORM

Date Referred: _____

Please help us in our efforts to expedite the referral process and provide better service to your Consumer by providing all of the information requested below.

Consumer's Name_____ Date of Birth _____

Address _____ City _____ State _____Zip _____

Home Phone # _____ Cell Phone # _____Work Phone # _____

Sex _____ Race _____ Consumer email: _____

Does Consumer have a legal guardian? _____ If yes, give name & address _____

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Payee's Name/ Office _____

Address _____

Phone #_____ FAX #_____

Email _____

* * * * * * * * * * * * * *

Primary Disability_____

Date of Onset _____ Secondary Disability (If applicable) _____

* * * * * * * * * * * * * *

Service(s) requested:

- ☐ **Assistive Devices for Independent Living**
- ☐ **Computer Access**
- ☐ **Educational Technology**
- ☐ **Worksite Assessment**
- ☐ **Home Assessment**

Please email completed form to contact below:

Pace Assistive Technology Services LLC
Kimberly Pace, MSBE, ATP, Owner
email: Kimberly@PaceATS.com
phone: (504) 201-5074

Engineering Services Requested (Please be specific)

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