Patient and Healthcare Provider Information Form

- This form ensures that EnableUC will only provide devices to recipients in alignment with the care plan set forth by the recipients' healthcare professional(s) per Ohio Rule 4755-70-01.
- This form is to be completed and signed by all three parties (EnableUC, Device Recipient or Guardian, and Healthcare provider) BEFORE EnableUC will furnish the device recipient with a device.
- EnableUC will store the completed form on their Microsoft SharePoint site in a private folder. EnableUC will furnish the completed form to the Device Recipient and/or Healthcare Provider upon request.
- DEVICE RECIPIENT refers to the individual (or their legal guardian) who will wear the device provided by EnableUC.

Device Recipient Information

Last Name

First Name

Device Recipient Over 18?

If Under 18, Specify Age

Cell Phone

Home Phone

Work Phone

Email Address

Preferred Contact Method

Signature of Device Recipient
(If 18 years of age or older)

Date

Use Below Section if Device Recipient is Under the Age of 18

Guardian Name (Print)

Relationship to Device Recipient

Signature of Guardian

Date

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Healthcare Provider

Healthcare Provider Name | **National Provider Identifier (NPI #)**

Healthcare Provider Practice OR Licensure (please mark the appropriate box. For non-Ohio based practices, use applicable rules from your local jurisdiction)

- ☐ Registered Nurse (Ohio Revised Code Chapter 4723)
- ☐ Pharmacist (ORCC 4729)
- ☐ Physician Assistant (ORCC 4730)
- ☐ Physician (ORCC 4731)
- ☐ Occupational Therapist, Physical Therapist, or Athletic Trainer (ORCC 4755)
- ☐ Orthotist
- ☐ Prosthetist
- ☐ Pedorthist (ORCC 4779)

Address

City | **State** | **ZIP Code**

Office Phone | **Office Fax**

Office Email | **After Hours Contact**

Statement of Acknowledgement:

- **Provider understands and agrees to allow EnableUC to provide the device recipient with a 3D printed open source upper limb prosthetic**
- **Provider states that their scope of medical care for the device recipient qualifies them to allow the provision of a prosthetic device**

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- **Provider agrees to facilitate care for the device recipient on any medical needs pertaining to the prosthetic**

Authorized Signature	**Authorized Name (Print)**
Signee Title	**Date**

EnableUC

Statement of Acknowledgement:

- **EnableUC agrees to cooperate with and defer to listed medical professional at all times**
- **EnableUC agrees to furnish the completed form to the Device Recipient or the Healthcare Provider upon request**

EnableUC Project Lead Name (Print)	**Phone Number**
Project Lead Signature	**Date**
EnableUC President (Print)	**Phone Number**
President Signature	**Date**