

AMPUTEE PEER VISIT REQUEST

I, the patient, would like to be connected with a Certified Peer Visitor (CPV). I give P&O Care permission to provide the CPV with the information included on this form in order to schedule the peer visit.

First Name: _____

Last Name: _____

Amputation Level:

Gender:

Age: _____

Upper Extremity

Male

Above Knee

Female

Below Knee

The best way for a CPV to contact me is:

Phone: _____

Email: _____

I am available for a Peer Visit:

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Peer Visit Location: _____

Peer Visits should be conducted in a hospital, therapy/rehabilitation/skilled nursing facility, doctor's office or public setting.

The Amputee Coalition of America requires amputee peer visits to be conducted upon request by the patient **ONLY**. Your privacy is important to us. This form will be used by Prosthetic and Orthotic Care to select the most appropriate Peer Visitor based on your gender, age and amputation level. CPVs are bound to the Amputee Coalition's Code of Ethics as well as HIPAA regulations. I understand that CPVs are volunteers, not employees of P&O Care and do not promote services or prosthetic components provided by P&O Care, rather they provide support and hope during the rehabilitation process.

My signature indicates I, the patient, have requested the peer visit and allow P&O Care to release the information provided on this form to a Certified Peer Visitor to schedule a visit.

Patient Signature

Date

HEALTH PROVIDERS / PATIENTS:

Fax completed form to 314-775-2045 or
email to Irehme@pandocare.com.

To schedule immediately, call 314-226-6704

INTERNAL USE ONLY:

CPV _____ Visit completed _____