





ABILITY UNLIMITED  
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**ABILITY UNLIMITED INTAKE FORM**

**PRIMARY CARE DOCTOR**

PCP Name:

Fax Number:

Phone:	E-mail:

**THERAPIST INFORMATION**  
 Speech, Occupational, Physical, Audiologist, or other

Name:

Fax Number:

Phone:	Email:
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**OTHER THERAPIST INFORMATION**

Name:

Fax Number:

Phone:	Email:
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**How have you managed in the past and currently without the AT/EM? (be detailed in your answer)**

**Have any recent changes necessitated the request? (be detailed in your answer)**

Please feel free to fax this confidential information to: [800-704-6216](tel:800-704-6216)  
 If you would like to send your documents via email:  
 please let us know and we will send you a **secure email** to reply to with your attachments.  
 You can also upload your document on our website at: [www.abilityunlimited.net](http://www.abilityunlimited.net)