Clinician: _____

REACH Clinic — DDS Northeast Region

Regional **E**valuation and **A**ssessment for **C**ommunity **H**abilitation

INTAKE FORM

1. INDIVIDUAL: REFERRAL DATE: _____

NAME: _____ SEX: _____ DOB: _____

STREET: _____ PHONE: _____

CITY/TOWN: _____ STATE: MA ZIP CODE: _____

DIAGNOSIS: _____

2. PARENT/GUARDIAN:

NAME: _____ PHONE: _____

ADDRESS: (If different) _____

CITY/TOWN: _____ STATE: MA ZIP CODE: _____

3. REFERRAL SOURCE INFORMATION:

Service Coordinator: _____ NS, 978-927-11 Ext: _____

Origin of Referral: ☐ Residence ☐ Day Support ☐ ISP ☐ Family ☐ Other: _____

Do you want to be contacted prior to the scheduling of this evaluation: ☐ Yes ☐ No

5. OTHER REFERRALS PURSUED: ☐ Yes ☐ No

6. PAST CLINICAL EVALUATIONS: (If available, Please attach copies)

7. CURRENT SERVICE PROVIDERS:

RESIDENTIAL	**DAY**	**CLINICAL** (OT, PT, ST, Other)
NAME OF AGENCY:	NAME OF AGENCY:	NAME OF AGENCY:
CONTACT PERSON:	CONTACT PERSON:	CONTACT PERSON:
Address:	Address:	Address:
City/State:	City/State:	City/State:
Phone:	Phone:	Phone:
Cell:	Cell:	Cell:
E-Mail:	E-Mail:	E-Mail:

8. PHYSICIANS / HEALTH INSURANCE INFORMATION: (Primary Care Physician information is **VERY** important)

PRIMARY CARE PHYSICIAN: Dr. _____ PHONE: _____, FAX: _____

ADDRESS: _____

MASS HEALTH (MMIS): ☐ Yes ☐ No Insurance No: 1000-_____ (MMIS number 1000-_ _ _ _ _ _ _ _) + 8 digits after it)

MEDICAID:..... ☐ Yes ☐ No Insurance No: _____ - _____ (Medicaid number is Social with 1 digit after it)

MEDICARE: ..... ☐ Yes ☐ No Insurance No: _____ - _____ (Medicare always has a letter or letter + 1 digit after it)

OTHER:..... Insurance No: _____

9. MEANS OF COMMUNICATION: **PRIMARY LANGUAGE SPOKEN/ UNDERSTOOD**: English

☐VERBAL ☐ GESTURAL ☐ SIGN ☐OTHER: _____

10. BRIEF SUMMARY: REASON for REFERRAL:

NOTE: If you are requesting a Low Vision or an Orientation and Mobility Assessment, please include copies of the most recent eye reports.