(Office Use) **Date Received:** **Referred To:**

Please
E-mail Completed form to:
susanbanks@state.ma.us

Please Cc:
DDS Area Director

Thank you!

Orientation & Mobility/Low Vision Services
Request for Services

Name:	
Date of Referral:	
Home Address: **Type:** ☐ **Group Home** ☐ **Shared Living** ☐ **Lives Alone** ☐ **Lives with Parents/Family** ☐ **Other:** **Contact Person:** **Phone #:** **Email:**	
Date of Birth:	
DDS Service Coordinator:	**Telephone:**
Area Office:	**Email:**
Day Services/Employment: **Address:** **Type:** ☐ **Vocational** ☐ **Day Habilitation** ☐ **Supported Employment** ☐ **Other:** **Contact Person:** **Phone #:** **Email:**	

Service Requested:

- ☐ Orientation and Mobility Assessment
- ☐ Environmental Assessment
- ☐ Residential Staff Training
- ☐ Day/Work Staff Training
- ☐ Direct Certified Orientation and Mobility Specialist Services
- ☐ Direct Vision Rehabilitation Assistant Services

☐ Other:

Reason for Referral:

Language Spoken:

Medical Health Issues:

Mental Health Issues:

Medications:

Behavioral Issues:

Eye Care Provider Information: **Date of most recent eye exam:**

Name:
Address:
Phone #:

Please check:
☐ **Ophthalmologist** ☐ **Optometrist**

Primary Care Provider Information:

Name:
Address:
Phone #:

Should DDS Service coordinator be contacted prior to first visit?

Others to be contacted/applicable:

Parent/Guardian:	Email:	Phone:
Physical Therapist:	Email:	Phone:
Occupational therapist:	Email:	Phone:
Speech Pathologist:	Email:	Phone:
Other Specialist:	Email:	Phone:

Please give a description of what goals you have for individual receiving this service:

Any other concerns/questions you would like to have addressed with Orientation and Mobility Services?