(Office Use)
Date Received:

Referred To:

Please email completed form to:
Teryl.Smith@mass.gov
Please cc: DDS Area Director and
Lisa.DiBonaventura@mass.gov
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 Name:

Address:

Phone #:

☐ **Ophthalmologist** ☐ **Optometrist**

Date of most recent eye exam:

Primary Care Provider Name:

Address:

Phone #:

Should DDS Service coordinator be contacted prior to first visit? ☐ Yes ☐ No

<u>Others To Be Contacted (if applicable)</u>

Parent/Guardian:	**Email:** **Phone:**
Occupational Therapist:	**Email:** **Phone:**
Physical 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?