

(Office Use)

Date Received:

Referred To:

Please email completed form to:
anthony.m.keane@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: <input type="checkbox"/> Group Home <input type="checkbox"/> Shared Living <input type="checkbox"/> Lives Alone <input type="checkbox"/> Lives with Parents/Family <input type="checkbox"/> Other:	
Contact Person:	
Phone #:	Email:
Date of Birth:	
DDS Service Coordinator:	Telephone:
Area Office:	Email:
Day Services/Employment:	
Address:	
Type: <input type="checkbox"/> Vocational <input type="checkbox"/> Day Habilitation <input type="checkbox"/> Supported Employment <input type="checkbox"/> 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:

