Commonwealth of Massachusetts
Department of Developmental Services
METRO REGION CLINICAL REFERRAL FORM

Date of Referral:_____

INDIVIDUAL:

Name:_____ DOB: _____

Street:_____ City/Town:_____

Phone:_____

Diagnosis: _____

PARENT/GUARDIAN:

Name:_____ Phone:_____ Email:_____

Street:_____ City/Town:_____ State:_____

☐ Own person ☐ Medical only ☐ Full ☐ HCP (invoked)

SERVICE COORDINATOR/REFERRAL SOURCE:

Name: _____ Area Office:_____

Phone: _____ Email:_____

CURRENT SERVICE PROVIDERS:

Residential	Day/Employment
Agency: _____	Agency: _____
Primary Contact: _____	Primary Contact: _____
Address: _____ Phone:_____ Cell:_____ Email:_____	Address: _____ Phone:_____ Cell:_____ Email:_____

HEALTH CARE INFORMATION:

Primary Care Physician:_____ Phone:_____ Email/fax:_____

Street:_____ City/Town:_____

Eye Doctor:(Vision Services referral only)_____ Phone:_____ Email/fax:_____

Street:_____ City/Town:_____

Mass Health: ☐ YES ☐ NO Insurance Number: _____

Medicare: ☐ YES ☐ NO Insurance Number:_____

Other Insurance ☐ YES ☐ NO Insurance Number: _____ Company:_____

DEMOGRAPHICS:

Vision: ☐ Within normal limits ☐ Low Vision ☐ Legally Blind

Hearing: ☐ Within normal limits ☐ Hard of Hearing ☐ Deaf

Mobility Status: ☐ Walks Independently ☐ Uses a cane/walker ☐ Uses a wheelchair

Height:_____ Weight:_____

☐ Verbal ☐ Gestures ☐ Signs ☐ Assistive Device ☐ Non-verbal

Preferred Language: _____ Interpreter: ☐ YES ☐ NO

SERVICE REQUESTED:

☐ Occupational Therapy/Physical Therapy ☐ Vision Services

Reason for Referral:

Special Circumstances:

6/16/22