(Office Use)
Date Received:

Referred To:

Please
E-mail Completed form to:
Lisa.DiBonventura@State.ma.ma

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:** **Primary Language:** **Contact Person/role:** **Phone #:( ) -** **Email:** **Language Spoken:**	
Date of Birth:	**Guardian Y N (list name on 3rd pg.)**
DDS Service Coordinator:	**Telephone:**
Area Office:	**Email:**
Day Services/Employment: **Address:** **Type:** ☐ **Vocational** ☐ **Day Habilitation** ☐ **CBDS/ Community** ☐ **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
☐ Other:

Reason for Referral/ Desired Outcome:

Mental Health/ Behavioral Concerns:

Medications:

Medical Health Issues:

Eye Care Provider Information:

Date of most recent eye exam:

Cause of Legal Blindness:

Name:
Address:
Phone#:

Primary Care Provider Information:

Name:
Address:
Phone#:

Guardian Information:
Should Guardian be contacted? Y/N

Name:
Address:
Phone#:
Email:

Should DDS Service coordinator be contacted prior to first visit? YES / NO (circle one)

Others to be contacted/applicable:

Physical Therapist: Email: Phone:

Occupation Therapist: Email: Phone:

Other:

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

***Please attach a copy of the most recent ISP, the Health Record, and ANY Behavioral Guidelines or Leveled Plans**