(Office Use)
Date Received:

Referred To:

Please email completed form to:
Lisa.DiBonaventura@mass.gov
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 page 3.)**
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 Name:

Address:

Phone#:

Date of most recent eye exam:

Cause of Legal Blindness:

Primary Care Name: **Address:** **Phone#:**	
Guardian Name: **Address:** **Phone#:** **Email:** **Should Guardian be contacted?** ☐ Yes ☐ No	
Should DDS Service Coordinator be contacted prior to first visit? ☐ Yes ☐ No	
Occupational Therapist:	**Email:** **Phone:**
Physical Therapist:	**Email:** **Phone:**
Speech Pathologist:	**Email:** **Phone:**
Other Specialist:	**Email:** **Phone:**
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.**