(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:**

DDS Supportive Technology Assessment Information: Promoting Collaboration

Please provide information as relevant # 1, 2 or 3. Thank you!

1. **Assessment Complete or In Process:**

   Name of Evaluator/Agency:

   Evaluator Email/Phone:

   Has assessment been completed? ☐ Yes. Date: ☐ Not yet completed

   • Please attach copy of AT assessment.

2. **Awaiting or Considering Assessment:**

   ☐ AT Referral was submitted. Date: ☐ AT referral not sent but being considered.

   • When/if AT Evaluator has been assigned, please share contact info with assigned COMS.

3. ☐ **No Supportive Technology Assessment is being considered or needed at this time.**

Any other concerns/questions to be 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.**