**WRENTHAM DEVELOPMENTAL CENTER**

**Request for Services**

Complete all sections of the form below, attaching relevant medical documentation as required.

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| Consumer Name:       | Date of Referral: Click or tap to enter a date. |
| Home Address:       | Contact Person at Home:      Phone:      Email:       |
| Service Coordinator:      Area Office:       | Service Coordinator Phone:      Email:       |
| Day Program: [ ]  Vocational [ ]  Supported Employment [ ]  Day Habilitation [ ]  Other:       |
| Day Program Address:       | Day Program Contact Person/Title:     Phone:      Email:       |
| Evaluation(s) being requested: [ ]  Physical Therapy [ ]  Occupational Therapy [ ]  Adaptive Design (ATRC) [ ]  Adapted Physical Education (APE)**\*** [ ]  O&M/Low Vision Assessment**\*\*** [ ]  Speech Therapy [ ]  One**Sight****\***All APE requests must include the following two forms, signed and dated within 45 days of the request: 1. Medical Clearance 2. Health Review for Participation in an Exercise Program**\*\***Please email, fax, or mail current eye reports to Lisa DiBonaventura, Lisa.DiBonaventura@mass.gov Address: Wrentham Developmental Center, PO Box 144, Wrentham, MA 0209. Fax: 508.384.6771  |
| Reason for referral:       |
| List Community Resources that have been explored (including dates of contacts and why service was not provided):1.
2.
3.

Additional comments:       |
| **IDENTIFYING DATA** |
| Date of Birth: Click or tap to enter a date. Language spoken:      Diagnosis:      Functioning level:      Psychiatric diagnosis:      Medical/Health concerns:      Behavioral and/or Mental health concerns:      Other relevant information:       |
| **Adaptive Design/Assistive Technology Request** |
| What assistive technology (AT) is currently being used (if any)?      Is the technology meeting the consumer’s needs? [ ]  Yes [ ]  NoPlease explain why it is/is not working.       |
| **Orientation and Mobility/Low Vision Assessment Request** |
| Eye Doctor Name/Practice:       [ ]  Optometrist [ ]  OphthalmologistPhone:      Address:       |
|  **OneSight Charitable Program Request** |
| Contact person:       Phone:      Email:      Mailing Address:      | LensCrafters Store Mailing Address:     Phone:      Contact person:      Email:      Date of prescription: Click or tap to enter a date. |
| Please describe other sources of payment that have been explored:       |
| **PT/OT/APE/ATRC requests**:1. Forward completed request to Area Director/Assistant Area Director for review and approval.
2. Forward completed request, supporting documentation, and Area approval to the following individual:

Cynthia VanVoris, Director of Social Services cynthia.p.vanvoris@mass.govWrentham Developmental CenterP.O. Box 144Wrentham, MA 02093 | **Orientation and Mobility/Low Vision Assessment/OneSight requests:**Forward completed request and supporting documentation to:Lisa DiBonaventura, MA, COMS,Statewide Director, Vision and Vision Loss ServicesLisa.DiBonaventura@mass.gov Wrentham Developmental CenterP.O. Box 144Wrentham, MA 02093Fax: 508.384.6771Cc: Cynthia VanVoris, Director of Social Servicescynthia.p.vanvoris@mass.gov |