**WRENTHAM DEVELOPMENTAL CENTER**
**Request for Services**

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

| Consumer Name: | Date of Referral: |
|---|---|
| Home Address: | Contact Person at Home:<br>Phone:<br>Email: |
| Service Coordinator:<br>Area Office: | Service Coordinator Phone:<br>Email: |

Day Program: ☐ Vocational ☐ Supported Employment ☐ Day Habilitation ☐ Other:

| Day Program Address: | Day Program Contact Person/Title:<br><br>Phone:<br>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: 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)?<br><br><br><br>Is the technology meeting the consumer's needs? ☐ Yes ☐ No<br>Please explain why it is/is not working. |

| Orientation and Mobility/Low Vision Assessment Request |
|---|
| Eye Doctor Name/Practice:<br>☐ Optometrist ☐ Ophthalmologist<br>Phone:<br>Address: |

| OneSight Charitable Program Request | |
|---|---|
| Contact person:<br>Phone:<br>Email:<br>Mailing Address: | LensCrafters Store Mailing Address:<br><br><br>Phone:<br>Contact person:<br>Email:<br>Date of prescription: |
| Please describe other sources of payment that have been explored: | |

| **PT/OT/APE/ATRC requests**: | **Orientation and Mobility/Low Vision Assessment/OneSight requests:** |
|---|---|
| 1. Forward completed request to Area Director/Assistant Area Director for review and approval.<br>2. Forward completed request, supporting documentation, and Area approval to the following individual:<br>Cynthia VanVoris, Director of Social Services<br>cynthia.p.vanvoris@mass.gov<br>Wrentham Developmental Center<br>P.O. Box 144<br>Wrentham, MA 02093 | Forward completed request and supporting documentation to:<br>Lisa DiBonaventura, MA, COMS,<br>Statewide Director, Vision and Vision Loss Services<br>Lisa.DiBonaventura@mass.gov<br>Wrentham Developmental Center<br>P.O. Box 144<br>Wrentham, MA 02093<br>Fax: 508.384.6771<br>Cc: Cynthia VanVoris, Director of Social Services<br>cynthia.p.vanvoris@mass.gov |