**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 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 [ ]  OneSight\*All APE requests must include the following two forms, signed and dated within 45 days of 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.govAddress: Wrentham Developmental Center, PO Box 144, Wrentham, MA 02093 Fax: 508.384.6771 |
| Reason for referral:       |
| List Community Resources that have been explored (including dates of contact 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:       |

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| **Adaptive Design/Assistive Technology Request** |
| What assistive technology (AT) is currently being used (if any)?       |
| Is the technology meeting the consumer’s needs? [ ]  Yes [ ]  No |
| Please explain why it is/is not working.       |
| **Orientation and Mobility/Low Vision Assessment Request** |
| Eye Doctor Name/Practice:       |
| [ ]  Optometrist [ ] Ophthalmologist |
| Phone:       |
| Address:       |
| **DDS Supportive Technology Assessment Information: Promoting Collaboration: COMS and AT** |
| 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: Click or tap to enter a date. [ ]  Not yet completed |
| * Please attach copy of AT assessment.
 |
| 1. **Awaiting or Considering Assessment:**
 |
| **[ ]** AT Referral was submitted. Date: Click or tap to enter a date. [ ]  AT referral not sent but being considered. |
| * When/if AT Evaluator has been assigned, please share contact info with assigned COMS.
 |
| 1. **[ ]  No Supportive Technology Assessment is being considered or needed at this time.**
 |
| **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:** | **O&M/Low Vision Assessment/OneSight Requests:** |
| 1. Forward completed requests to Area Director/Assistant Area Director for review and approval.
2. Forward completed request, supporting documentation, and Area approval to:

Kristen Cook, Social Services SupervisorKristen.K.Cook@mass.govWretham Developmental CenterP.O. Box 144Wrentham, MA 02093 | Forward completed request and supporting documentation to: Lisa DiBonaventura, MA, COMSStatewide Director, Vision and Vision Loss ServicesLisa.DiBonaventura@mass.govWrentham Developmental CenterP.O. Box 144Wrentham, MA 02093Fax: 508.384.6771cc: Kristen Cook, Social Services SupervisorKristen.K.Cook@mass.gov |