**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.gov](mailto:Lisa.DiBonaventura@mass.gov)  Address: 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 Supervisor  [Kristen.K.Cook@mass.gov](mailto:Kristen.K.Cook@mass.gov)  Wretham Developmental Center  P.O. Box 144  Wrentham, MA 02093 | Forward completed request and supporting documentation to:  Lisa DiBonaventura, MA, COMS  Statewide Director, Vision and Vision Loss Services  [Lisa.DiBonaventura@mass.gov](mailto:Lisa.DiBonaventura@mass.gov)  Wrentham Developmental Center  P.O. Box 144  Wrentham, MA 02093  Fax: 508.384.6771  cc: Kristen Cook, Social Services Supervisor  [Kristen.K.Cook@mass.gov](mailto:Kristen.K.Cook@mass.gov) |