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: 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
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: 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 ☐ 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: ☐ 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.**

OneSight Charitable Program Request

Contact Person: Phone: Email: Mailing Address:	LensCrafters Store Mailing Address: Phone: Contact Person: Email: Date of Prescription:

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 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 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