



# Referral for Orientation and Mobility Services

SERVICES, INCORPORATED

Referral Date: \_\_\_\_\_

Please return to John Higgins, COMS: [invision@mindspring.com](mailto:invision@mindspring.com) Fax: 919-732-6624

Referring Counselor: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Release of information included with this referral:    yes            no

Client: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Preferred Method of contact by Client: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Spouse/Caregiver: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Dx: \_\_\_\_\_ Eye Report Included:    yes            no

\_\_\_ Macular Degeneration                      \_\_\_ Glaucoma

\_\_\_ Diabetic Retinopathy                        \_\_\_ Retinite Pigmentosa

\_\_\_ Other: \_\_\_\_\_

Distance Acuity:    \_\_\_ OD    \_\_\_ OS

Fields:                \_\_\_ OD    \_\_\_ OS

Other Disabilities: \_\_\_\_\_

Learning Style (tactual, auditory, visual, other): \_\_\_\_\_

Prescribed Devices:    \_\_\_ Cane    \_\_\_ Magnification    \_\_\_ Other: \_\_\_\_\_

Interpreter required:    yes            no    Language: \_\_\_\_\_

Requested Services: \_\_\_\_\_ Suggested Start Date: \_\_\_\_\_

In Home Mobility: \_\_\_\_\_

Community Mobility: \_\_\_\_\_

Work Site Mobility: \_\_\_\_\_

Work Site contact information: \_\_\_\_\_

Service Comments: