Office of Rehabilitation Services

Services for the Blind and Visually Impaired

40 Fountain Street ~ Providence, RI 02903

INTAKE FORM

TARGET PROGRAM: IL☐ ILOB☐ CHILD ☐ VR ☐

PRIOR CASE: ☐YES ☐NO PROGRAM: ______________________________

PRIOR CODING: ☐PLB ☐LB ☐PVH ☐VH Most Recent Date Coded: ______________________

NAME: ______________________________ DATE OF BIRTH: ______________________________

SSN: ______________________________

PHONE: ______________________________ EMAIL: ______________________________

ADDRESS: ____

____

LIVING ARRANGEMENT: ____

MEDICAL COVERAGE: ☐YES ☐NO : Type: ______________________________________

REFERRED BY:(Name): ______________________________ (Phone): ______________________

OTHER AGENCY INVOLVEMENT: ____

PREFERRED LANGUAGE/MEDIA: ____

VISUAL IMPAIRMENT/DIAGNOSIS: ____

____

OPHTHALMOLOGIST/EYE DR: ____

____

OTHER CONDITIONS: ____

HEARING IMPAIRED: ☐ YES ☐ NO

VETERAN STATUS: ☐ YES ☐ NO

REASON FOR REFERRAL:

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CURRENTLY EMPLOYED: ☐YES ☐NO INTERESTED IN VR SERVICES: ☐YES ☐NO

OTHER INFO: ____

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INTAKE WORKER: ______________________________ DATE: ______________________________