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| **Texas Workforce Solutions logo** | | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Orientation and Mobility (O&M) Referral** | | | | | |
| **Customer Information (required)** | | | | | | | | |
| VR Counselor or Independent Living Services for Older Individuals who are Blind (ILS-OIB) worker name: | | | Caseload Number: | | Office Number:  (   ) | | | |
| O&M Provider: | | | Date of Referral: | | | | | |
| Customer Name: | | | DOB: | | | Primary Language: | | |
| Customer Address: | | | City: | | | State: | ZIP Code: | |
| Telephone Number:  (   ) | | | Alternate Contact:  (   ) | | | | | |
| Best Day(s) to Contact (if known): | | | | | | | | |
| Customer’s and/or VR Counselor or IL/OIB worker travel concerns: | | | | | | | | |
| **Reason for Request (required)** | | | | | | | | |
| O&M Goal(s) of the Customer: *check box(s) below that may apply* | | | | | | | | |
| Guided technique(s)  Evaluation purposes only  Orientation to home  Orientation to surrounding community  Basic indoor cane skills  Residential travel  Semi-business travel  Negotiate stairs | | | | Orientation Skills with dog guide  Use of Para transit  Business travel  Dog guide information  Travel in familiar areas  Travel to unfamiliar areas  Unsure if O&M Skills are needed  Other O&M goals (please describe) | | | | |
| **Circumstances that May Impact Services (required)** | | | | | | | | |
| Visual Diagnosis: | | | Secondary Disability: | | | | | |
| If secondary disability is deaf blindness, what is the customer’s primary form of communication? | | | | | | | | |
| **Helpful Information (complete if known)** | | | | | | | | |
| Level of Education: | Known Health Issues/ Safety Concerns: | | | | | | | |
| Visual Acuity: | OD: | | OS: | | Visual Fields: | | | |
| Additional Information: | | | | | | | | |