



Consumer's Name: \_\_\_\_\_

Consumer's Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Dates of Instruction: \_\_\_\_\_

**Topics Covered: (check appropriate boxes)**

- |  |  |
|--|--|
| <input type="checkbox"/> Sighted Guide         | <input type="checkbox"/> Room Familiarization              |
| <input type="checkbox"/> Doorways              | <input type="checkbox"/> Locating Chairs                   |
| <input type="checkbox"/> Stairs                | <input type="checkbox"/> Entering & Exiting Van/Car        |
| <input type="checkbox"/> Protective Techniques | <input type="checkbox"/> Basic Orientation to Meeting Site |
| <input type="checkbox"/> Trailing              | <input type="checkbox"/> Other _____                       |
| <input type="checkbox"/> Locating Items        |  |

**Additional Services: (check appropriate boxes)**

- Standard Cane Provided---Length: \_\_\_\_\_
- Noir Sunglasses Recommended---Style and Tint: \_\_\_\_\_
- Familiarization with Home Setting
- Use of Cane
- Orthopedic Cane Provided---Length: \_\_\_\_\_
- Oriented to Public Transportation
- Other: \_\_\_\_\_

**Special Services Provided:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Special Services and/or Devices Needed:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
**Orientation and Mobility Specialist (Signature)**

\_\_\_\_\_  
**Date**

cc: Orientation and Mobility Specialist Record  
 Referral Source Record