DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Public Health
F-22491 (07/2016)

CONSUMER REPORT

Name – Consumer (Last, First, Middle Initial)		Rehab Office Location	
Mailing Address		City	Zip Code
County		Telephone Number	
Date of Birth	Gender ☐ Female ☐ Male	Date of Onset of Significant Loss	

Race / Ethnicity
Select One

Source of Referral
Select One

Degree of Visual Impairment
Select One

Primary Visual Disability
Select One

Other Visual Disabilities if Applicable

☐ 1 Cataracts ☐ 2 Diabetic Retinopathy ☐ 3 Glaucoma

☐ 4 Macular Degeneration ☐ 5 Other – List

Other Disabilities

☐ 1 Alzheimer's Disease / Cognitive Impairment ☐ 2 Bone, Muscle, Skin, Joint, Movement Disorder

☐ 3 Cancer ☐ 4 Cardiovascular Disease and Strokes

☐ 5 Depression / Mood Disorder ☐ 6 Diabetes

☐ 7 Hearing Impairment ☐ 8 Other Major Geriatric Concerns – List:

Highest Level of Education Completed	Type of Living Arrangement at Intake	Type of Living Arrangement at Exit
Select One	Select One	Select One

Type of Residence at Intake
Select One

Type of Residence at Exit
Select One

Adaptive Aids, Devices or Equipment Provided

☐ Assistive Technology Devices and Aids ☐ Assistive Technology Services and Training

Types of Training / Services Provided

☐ Advocacy Training & Support Networks ☐ Low Vision Training

☐ Communication Skills ☐ Orientation and Mobility Training

☐ Counseling (peer, individual and group) ☐ Other IL Services – Specify:

☐ Daily Living Skills

☐ Information, Referral and Community Integration ☐ Supportive Services (reader, transportation, interpreter, attendant, support service provider, etc.)

☐ Low Vision Exams / Screening ☐ Referral to Rehab Specialist – Date

Service Start Date	**NAME** – Agency Representative
Service End Date	**NAME** – Agency Representative

DISTRIBUTION: Original – Service Provider; Copy – OBVI Central Office; Copy – Rehabilitation Specialist