Referral Form

1. Identifying Information

Name: ______________________________

Referral Agent: ______________ DOB: ______________ Sex: ________

Address: ______________________________

Referral Agency: ______________ Race: ______________ County: ________

Social Security Number: ______________ Phone: ______________

Referral number (Medicaid, VR#, etc.) ______________________________

Medical Insurance (Medicaid, Medicare, Other)

Name: ______________________________ Number: ______________

2. Disability

Primary Disability: (needs supporting documentation) ______________________________

Secondary Disability: ______________________________

☐ MSD

☐ SD

Comments, if any: ______________________________

____

3. History

A. Medical History

Current Medications and Dosage: ______________________________

Is Client capable of administering own medication? ______________________________

Physical Limitations: ______________________________

Preferred Physician (if any) ______________________________

B. Educational History

Highest grade achieved: ______________________________

School: ______________________________ Year: ______________

Special Training received: (include area of training, place and time) ______________________________

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____

C. Vocational History

Job Goal: ______________________________ DOT Code: ______________________________

Work History: (include any prior employment, armed services, etc.) ______________________________

D. Social History

Financial Support: (Family, SSI, SSDI, VA): ______________________________

Legal Guardian: (Y/N): ______________________________

Contact Name in case of emergency: ______________________________

Address: ______________________________ Phone: ______________________________

E. Psychological History

Tests, Diagnosis, etc.: ______________________________

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F. Functional Limitations:

List limitations: ______________________________

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____

G. Strengths, Abilities, Needs and Preferences:

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____

4. Special Instructions

Diet, Seizures, Mobility Skills, Work Adaptations/Accommodations, etc.: ______________________________

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____

5. Primary Questions to Be Answered (Vocational Evaluation Only): ______________________________

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6. Transportation:

Transportation to be provided by: ____

____

7. Services Requested: (Please check all that apply)

☐ **Vocational Evaluation**

☐ Complete Evaluation
☐ Work Assessment

Information Required in Referral Packet:
DOI Referral Form, SD Document, Criminal History if applicable, R-4-VR Survey Form, Medical Records, Psychological

☐ **Work Adjustment In-House Training**

Information Required in Referral Packet:
DOI Referral Form, SD Document, Individual Plan for Employment (IPE) Criminal History if applicable, R-4-VR Survey Form, Medical Records, Psychological

☐ **Work Adjustment Job Coach**
☐ **Supported Employment**

Information Required in Referral Packet:
DOI Referral Form, SD Document, Individual Plan for Employment (IPE) Criminal History if applicable, R-4-VR Survey Form, Medical Records, Psychological

☐ **ADVP - Adult Developmental Vocational Program**

Information Required in Referral Packet:
DOI Referral Form, Medical Records, Psychological, NC SNAP, Current PCP if applicable

☐ **LTVS - Long Term Vocational Support**

Information Required in Referral Packet:
DOI Referral Form, Medical Records, Psychological, NC SNAP, Current PCP if applicable

Signature Referring Agent ______________________________ Date ____________________

Referring Agency ______________________________ *Revised April 2014*