



VOCATIONAL REHABILITATION & BLIND SERVICES

Referral for Services

Vendor:

Date of Referral: [Click to enter a date](#)

Next Appointment:

Counselor:

Name:

Date of Birth: [Click to enter a date](#)

Address:

Phone Number:

Email:

Job Goal:

I-9 Documents Verification: Yes No

Disability:

Case Manager/

Guardian Contact:

GENERAL

VR/BLVS

PRE-ETS

Psychological / Learning Disability Eval.

Job Search Assistance

Job Exploration Counseling

Functional Capacity Evaluation

Job Readiness Training

Work Based Learning

OT/PT/Ergonomic Evaluation

On the Job Supports

Experience Post-Secondary

Benefits Counseling

Technical Assistance

Educational Counseling

Individual Counseling

Customized Employment

Workplace Readiness Training

Independent Living Support

Discovery

Self-Advocacy Instruction

Job Placement

Other: Please Describe:

REFERRAL QUESTIONS AND REQUESTS Regarding this person, please assess, explore, and/or recommend:

Work Skills & Work Behaviors

Interests, Abilities, Limitations

Business Plan Development

Potential for Post-Secondary Academic

Functional Capacities

Success Academic Accommodations

Job Site Accommodations

Other: Please Describe:

ATTACHED INFORMATION

Signed Release

Educational Records

BPQY

Medical/Psychological Records

Authorizations

Individual Plan of Employment

Case Notes

DLO/Cert/Pre-ETS

Other: Please Describe: