|  |  |
| --- | --- |
| Authorization # |  |
| Client Name |  |
| Client Address |  |
| City |  |
| ZIP Code |  |
| Date of Birth |  |
| Preferred Phone Number |  |
| Secondary Phone Number |  |
| E-Mail |  |
| Emergency Contact Name |  |
| Emergency Contact Phone Number |  |
| Disability – Primary |  |
| Disability – Secondary |  |
| Functional Capabilities |  |
| Vocational Goal(s) to Explore: |  |

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| **Counselor: Please place a C:\Program Files\Microsoft Office\MEDIA\OFFICE12\Bullets\BD21301_.gif in the first column of all Referral Questions that need to be addressed during assessment. Include any clarifying comments or explanations. Email or fax completed form to the Institute** |
|  |  |
| **C:\Program Files\Microsoft Office\MEDIA\OFFICE12\Bullets\BD21301_.gif** | **Question** | **Comments** |
|  | What are the lifting/carrying/ergonomic issues, if any? |  |
|  | How many hours can the consumer work? |  |
|  | How long can the consumer can sit or stand without a break? |  |
|  | What are the productivity issues, if any? |  |
|  | How is the consumer’s grooming and hygiene, especially in relation to the work environment?  |  |
|  | How does consumer interact with others in the work setting? |  |
|  | How does the consumer focus on tasks? |  |
|  | How are the consumer’s skills in executive functioning (reasoning, judgment, memory), sequencing, and preferred learning styles? |  |
|  | How does the consumer demonstrate initiative and motivation to work? |  |
|  | How does the consumer adapt to change in his/her environment? |  |
|  | How does consumer manage time? |  |
|  | How does consumer handle feedback and stress? |  |
|  | Is the consumer able to handle the essential functions of the job(s) identified above? |  |
|  | What are consumer employment support systems including family or group home? |  |
|  | What are the consumer’s expressed vocational interests? |  |
|  | What are the consumer’s transportation issues? |  |
|  | Additional concerns or issues (explain)  |  |

|  |  |
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| **COUNSELOR INFORMATION** |  |
| Counselor Name |  |
| Office, Street Address |  |
| City, Zip Code |  |
| Telephone  |  |
| Fax |  |
| E-Mail |  |
| **ADDITIONAL COMMENTS:** |  |
| **COUNSELOR’S SIGNATURE & DATE** |  |
| **Please Check Documents Attached:** |  |
|  |  | Authorization  |
|  |  | Medical/ Non-Medical Release  |
|  |  | Other Relevant Information (i.e. Psych Summary, Medical Summary, Functional Evaluation Summary, etc.) |