DVR-35A (Revised 05/20/02)
(Attach to DVR-35)

CARL D. PERKINS COMPREHENSIVE REHABILITATION CENTER
REFERRAL CHECKLIST

NAME: _____ DATE: _____

REFERRING COUNSELOR: _____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

DOES THE CONSUMER HAVE A GUARDIAN? ☐YES ☐NO

GUARDIAN'S NAME: _____ PHONE NUMBER: _____

DOES THE CONSUMER HAVE A HEARING LOSS? ☐YES ☐NO IF 'YES' IS CHECKED, WHAT ACCOMMODATIONS WILL THIS CONSUMER NEED WHILE AT THE CENTER FOR EVALUATION AND/OR TRAINING? _____

_____

PROGRAM(S) REQUESTED (*Check one or more*)

- ☐ Comprehensive Vocational Evaluation (CVE)
- ☐ Work Adjustment Program (WAP)
- ☐ Brain Injury Program (BIP)
- ☐ Physical Restoration Program (PRP)
- ☐ Training (Please Specify)

  _____
- ☐ Out-Patient Services (Specify)

  _____
- ☐ Job Placement Services
- ☐ PACE

SPECIAL REQUEST(S) *(Check one or more)*

- ☐ Psychological Evaluation
- ☐ Neuropsychological Evaluation
- ☐ Speech Evaluation Therapy
- ☐ Occupational Therapy Evaluation/Therapy
- ☐ Physical Therapy Evaluation/Therapy
- ☐ Medical Evaluation
- ☐ Driver's Education Evaluation/Training
- ☐ GED/Developmental Education
- ☐ Rehab Technology
- ☐ Other: _____

SPECIFIC QUESTIONS/CONCERNS YOU WANT ANSWERED: _____

_____

_____

CONSUMER WILL BE A: ☐RESIDENT ☐DAY STUDENT

IS TRANSPORTATION NEEDED? ☐YES ☐NO
IF SO, WILL SPECIAL ASSISTANCE BE REQUIRED? (*Please Specify & provide phone numbers for contact*)

_____

_____

<u>DOCUMENTS REQUIRED</u>:

Please send the entire case record. To prevent delays in consumer services, it is best practice that you send up-to-date reports, if possible.

TRANSFER THE CASE TO CASELOAD 291963.