Commonwealth of Kentucky
Department of Vocational Rehabilitation

Rehabilitation Technology Services
Referral Form
(*to be completed by counselor*)

CLIENT INFORMATION

Date: _____ SS#: _____

Client Name: _____ Case Status: _____

Parent/Guardian/Advocate (if applicable): _____

DOB: _____ DOT Code: _____ Major Disability: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ County Code: _____

REFERRING COUNSELOR

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ District: _____

SERVICE REQUEST/REFERRAL PROBLEM

Description:

Travel Directions:

Contact Person: _____ Telephone: _____