Kentucky Office of Vocational Rehabilitation

Specialized Services Referral Form

Name: Case Number:

Referring Counselor: Date of Referral:

Services Required *(select all that apply)*

- ☐ Assistive Technology
- ☐ Bioptic Driving
- ☐ Deaf-Blind
- ☐ Independent Living / OIB
- ☐ Orientation and Mobility
- ☐ Vocational Rehabilitation

Service Location *(select all that apply)*

- ☐ Field Services
- ☐ McDowell Center
- ☐ Remote Services

Contact Information

Address:

City: State: Zip: County:

Phone: Email:

Preferred Communication Method: If other, please specify:

Preferred Contact Method: Consumer Type:

Other Professional

Please provide contact information for other professionals who should be involved in the services requested (i.e. supported employment providers, placement specialist, job coach, employer, etc.).

Professional 1:

Role 1:

Organization 1:

Phone 1:

Email 1:

Professional 2:

Role 2:

Organization 2:

Phone 2:

Email 2:

Disability Information

Disability:

Prognosis:

If other, please specify:

Has Student Had a Low Vision Evaluation?

List any low vision devices Student is using:

Medications:

Mobility Information

Mobility:

If other, please specify:

For wheelchair or scooter:

Make/ Model:

Year Obtained:

Funding Source:

Transportation Information

Current Transportation Method:

Does Consumer own or have plans to purchase a vehicle?

Make:

Model:

Year:

Education Information

Student:

School:

Anticipated Start Date:

Anticipated Completion Date:

Major:

Has the Student Contacted Disability Services?

List all approved accommodations:

Vocational Information

Current Working Status:

If other, please specify:

Employer:

Job Title:

Essential Job Functions:

Current Accommodations at Work:

Previous Assessments

Note: Reports should be available in CMS. *(select all that apply)*

- ☐ Assistive Technology
- ☐ Audiology
- ☐ Bioptic
- ☐ CDPVTC Services
- ☐ Independent Living
- ☐ IPE / 504 Plan
- ☐ Orientation & Mobility
- ☐ McDowell Center Services
- ☐ Neuropsych
- ☐ Post-Secondary
- ☐ Vision – Acuity
- ☐ Vision – Visual Fields
- ☐ Other

If other, please specify:

Assistive Technology Services

Type of Assistive Technology Services Requested: *(select all that apply)*

- ☐ Adaptive Computer Access
- ☐ Communication
- ☐ Computer Hardware Software
- ☐ Farm Modification
- ☐ Home Modification
- ☐ Independent Living
- ☐ Low Vision
- ☐ Mobility (Wheelchair)
- ☐ School Accommodation
- ☐ Work Accommodation
- ☐ Work from Home
- ☐ Other

If other, please specify:

Narrative Description of Requested Services:

Expectations:

Training areas:

Previous AT Assessment: Date of Last Assessment: Previous AT Provider:

Assistive Technology Consumer currently has:

Computer Equipment Consumer currently has:

Brand: Operating System: Year Purchased:

Computer Experience Level: Typing Skills:

iPad/ Tablet: Brand / Model: Year Purchased:

iPad/ Tablet Experience Level:

Smart Phone Equipment: Brand / Model: Year Purchased:

Smart Phone Experience Level:

Bioptic Driving

Previous Bioptic Driving Services: Most recent date of services:

Tint Evaluation Only?

Expectations:

Independent Living Services

Does the Consumer have an Open VR Case?

Previous Independent Living (IL) Services: Most recent date of IL services: ***(mm/yyyy)***

Description of previous IL Services recieved:

Current Independent Living Technology:

Current Independent Living Needs:

Orientation & Mobility Services

Previous O&M Services:

Most recent date of O&M services:

Expectations:

Training Areas:

Deaf-Blind Services

Previous Deaf-Blind Services?

Most recent date of Deaf-Blind services:

Expectations: