



**DEPARTMENT OF HUMAN SERVICES
OFFICE OF REHABILITATION SERVICES
40 Fountain Street ~ Providence, RI 02903
401.421.7005 (V) ~ 401.421.7016 (TTY)**

“Helping individuals with disabilities to choose, find and keep employment”

REFERRAL FORM TO ORS

DATE OF REFERRAL: _____ **REFERRAL FROM:** Self ___ or Agency Name _____

NAME: _____ **ADDRESS:** _____

ABILITY TO COMMUNICATE IN ENGLISH? Yes ___ No ___ **IF NOT, WHAT LANGUAGE?** _____

TELEPHONE: _____ **CELL:** _____ **E-MAIL:** _____

GENDER: Male ___ Female ___ **DOB:** _____ **SOCIAL SECURITY #:** _____

DISABILITY: _____ **MEDICATIONS (if any):** _____

PURPOSE OF REFERRAL: _____

ARE YOU/IS REFERRAL INTERESTED IN EMPLOYMENT: Yes ___ No ___

TYPE OF EMPLOYMENT/GOAL: _____

WORK HISTORY: _____

BARRIERS TO SUCCESSFUL EMPLOYMENT? _____

TRANSPORTATION: Car (independent) ___ Car (dependent) ___ **RIDE** ___ Bus ___ Other _____

Does customer require handicapped accessible transportation: Yes ___ No ___ Maybe ___

APPLIED FOR SSI/SSDI? Yes ___ No ___ **RESULT OF APPLICATION:** _____

EDUCATION: Highest Grade _____ **GED** _____ **Special Education** _____

Other Education or Training: _____

TABE Reading Level: _____ **TABE Math Level:** _____

OTHER ISSUES/CONCERNS: _____

Signature: _____

Date: _____

Phone #: _____

Fax #: _____

Revised 10/17/08