



**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

DATE OF REFERRAL: _____

REFERRAL FROM: _____ **REFERRAL TO:** _____

CUSTOMER NAME: _____ **ADDRESS:** _____

TELEPHONE: _____ **GENDER:** Male ___ Female ___ **DOB:** _____

DISABILITY: _____

MEDICATIONS (if any): _____

PURPOSE OF REFERRAL: _____

REFERRAL EXPECTATIONS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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

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

LIVING SITUATION: _____ **CHILD CARE ISSUES:** Yes ___ No ___ Unknown ___

INCOME: SSI ___ SSDI ___ FIP ___ FAMILY ___ UNEMPLOYMENT ___ WORKER’S COMP ___ OTHER _____

Are benefits an issue? Yes ___ No ___ Unknown ___

WORK HISTORY:

EDUCATION: Highest Grade _____ GED _____ Special Education _____

Other Education or Training: _____

Reading Level: _____ Math Level: _____

TYPE OF EMPLOYMENT /GOAL: _____

LIMITATIONS/RESTRICTIONS: _____

OTHER ISSUES/CONCERNS: _____

