Rehabilitation Technology Services Referral Form

Date:

Client Information: ***Please complete all fields!*** *(Fields will expand as you type)*

Name: Last First Middle	**Date of Birth:**
Address: Street City County State WV Zip	
Phone: (h) (w)	**Contact:** **Phone:**
SSN: xxx-xx-	**Email:**
Program: DRS VR Status:	**Case ID Number:**
Primary Disability: **Code:**	**Secondary Disability:** **Code: 9999**

Referral Source:

Name Last First	**Phone** **Fax**
Address: Street City State Zip	**Territory:**

Services Requested: *(Please check all that apply)*

Work Site or Training Site Services *Rehab Engineering or Assistive Technology Unit*

☐ **Work Site Evaluation**	☐ **Adaptive Equipment Evaluation**
☐ **Computer Access Evaluation**	☐ **Other** *(please specify)***:**

Home Modification Services (*see page 2*) *Rehab Engineering or Environmental Modification Unit*

☐ **Home Modification Evaluation**	☐ **Other** (please specify)**:**

Driving or Vehicle Modification Services (*see page 2*) *Driver Rehabilitation Unit*

☐ **Driver Evaluation**	☐ **Training**
☐ **Vehicle Modification Evaluation**	☐ **Other** (please specify):
☐ **Bioptic Driver Evaluation***	☐ **Bioptic Driver Training***

Please send most recent OT/PT or Physician narrative; or other relevant medical documentation if available.

Objective*:* *(Please briefly state the current status and desired outcomes of technology intervention)*

Directions: *(Please provide directions with street names, landmarks and mileage when possible)*

Send or email referrals to

Dale Castilla dale.t.castilla@wv.gov, AND Cindy Lokey cynthia.a.lokey@wv.gov.

* Send or email Bioptic Driving referrals to Chuck Huss chuck.p.huss@wv.gov.

WVDRS Rehabilitation Technology Dept. ♦ PO Box 1004 ♦ Institute, WV 25112 ♦ (304) 766-4756 ♦ fax 766-4814

Please complete PRIOR to referring for Home or Vehicle modification services.

HOME MODIFICATIONS

Home Ownership: ☐ Private property (owned by client)
☐ Rental or property not owned by client (requires owners written permission to modify)

Please select areas to address and list client accessibility issues:

Access Route:

☐ Driveway ☐ Exterior ramp/lift ☐ Exterior door ☐ Interior stair lift
☐ Client's bedroom door ☐ Client's bathroom door ☐ Other door
Issues:

Bathroom:

☐ Grab bars ☐ Tub transfer ☐ Barrier free shower ☐ Sink/vanity access
Issues:

Laundry:

☐ Client has primary responsibility for laundry. Please suggest modifications.
Issues:

Kitchen:

☐ Client has primary responsibility for meal preparation. Please evaluate the following:
☐ Wall Cabinets ☐ Base Cabinets ☐ Appliances ☐ Sink
Issues:

VEHICLE MODIFICATIONS

☐ Yes ☐ No	Does the client currently have transportation available or own a vehicle that can be modified?
☐ Yes ☐ No	If the client has no transportation available, are you requesting an evaluation to determine the most appropriate vehicle to purchase for modifications?

Reason for vehicle purchase and/or modifications:

☐ Participate in a training program
☐ Retain Employment
☐ Job Seeking / Placement

Comment:

All administrative exceptions must be obtained prior to referring to Rehabilitation Technology Services Unit for evaluations.

☐ Yes ☐ No	If an administrative exception to policy is required, have you obtained approval of this exception?