|  |  |
| --- | --- |
| Authorization # |  |
| Client Name |  |
| Client Address |  |
| City |  |
| ZIP Code |  |
| Date of Birth |  |
| Preferred Phone Number |  |
| Secondary Phone Number |  |
| E-Mail |  |
| Emergency Contact Name |  |
| Emergency Contact Phone Number |  |
| **ASSESSMENT INFORMATION** |
| Reason for Referral (Examples: *“Is nursing a good fit for this client?”* Or, *“In what areas does client’s behavior need to improve in order to become employed?”* |  |
| Disability — Primary |  |
| Disability — Secondary |  |
| Functional Capabilities |  |
| Vocational/Educational Goal |  |
| Additional Diagnostic Information |  |
| On-Campus Transportation Needed |  |
| Psychological/Medical Records Sent |  |
| **COUNSELOR INFORMATION** |  |
| Counselor Name |  |
| Office, Street Address |  |
| City, Zip Code |  |
| Telephone  |  |
| Fax |  |
| E-Mail |  |
| **ADDITIONAL COMMENTS:** |  |
| **COUNSELOR’S SIGNATURE & DATE** |  |
| **Please Check Documents Attached:** |  |
|  |  | Authorization  |
|  |  | Medical/ Non-Medical Release  |
|  |  | Other Relevant Information (i.e. Psych Summary, Medical Summary, Functional Evaluation Summary, etc.) |