|  |  |  |  |
| --- | --- | --- | --- |
| 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.) | |