ESS Assessment Referral

Referral to (Contractor): ____________________

Individual's Name: ____________________

Address: ____________________
Street Address *City* *State* *Zip Code*

Home Phone: ____________________ Cell Phone: ____________________

Date of Birth: ____________________
mm/dd/yy

Primary Disability: ____________________

Secondary Disability: ____________________

DRS Counselor Name: ____________________

Address (Office): ____________________
Street Address *City* *State* *Zip Code*

Phone: ____________________ Fax: ____________________

Type of Assessment Needed (Check all that apply):

ESS-C-353-1 — Cognitive

ESS-C-353-2 — Communication

ESS-C-353-3 — Computer Technology

ESS-C-353-4 — Daily Living

ESS-C-353-5 — Housing

ESS-C-353-6 — Mobility

ESS-C-353-7 — Work Tolerance

ESS-C-353-8 — Transportation

Other: (Write comment below)

Describe any problems the individual is having in the above assessment areas:

DRS Counselor Name: ____________________ Date: ____________________