

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-353-4 — Daily Living

ESS-C-353-7 — Work Tolerance

ESS-C-353-2 — Communication

ESS-C-353-5 — Housing

ESS-C-353-8 — Transportation

ESS-C-353-3 — Computer Technology

ESS-C-353-6 — Mobility

Other: (Write comment below)

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

DRS Counselor Name: _____

Date: _____