N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND
INDEPENDENT LIVING REHABILITATION

REFERRAL FOR ASSISTIVE TECHNOLOGY SERVICES

Referral to: _____ *Date*: _____

Referring Counselor: _____ *Office location*: _____

Name: _____ **Phone:** _____

Address: _____ **E-mail:** _____

_____

Technology Services needed for: Employment ☐ School/Training ☐ Job Development ☐
Independent Living ☐ Res. Modification ☐ BE Operator ☐

Service Requested: Assessment ☐ Set-up ☐ Follow-up ☐ Other ☐

Technology will be located: In Individual's Home ☐

At location of training ☐ _____ Date Training Begins _____
(*address*)

On the Job ☐ _____ Date of Employment _____
(*address*)

Individual: Is a Braille reader ☐ Uses low vision equipment ☐ Requires speech adaptation ☐
(Attach any existing assessment information)

Reason for Referral: _____

_____

Individual currently owns/has access to the following equipment (*include approx. age****)***:

_____

Previous AT Assessments/Training: _____

_____

Please attach: 1. Copy Rehabilitation/ILR Application (with current information)
2. Most recent eye information
3. Copy of Evaluation Unit, Rehabilitation Center, low vision evaluation, and/or skills assessment reports
4. Any technology assessments and/or training reports
5. Copy of IPE/ILP with any Amendments
6. DSB-0197 Request for Resident Modification form for home modifications

_____
Signature of DSB VR Counselor or ILR Counselor

EMAIL ADDRESS _____