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

REFERRAL FOR ASSISTIVE TECHNOLOGY SERVICES INSTRUCTIONS

PURPOSE

Referrals are made from the North Carolina Division of Services for the Blind (DSB) Vocational Rehabilitation (VR) Program and from the DSB Independent Living Rehabilitation (ILR) Program to the Assistive Technology (AT) Consultants, the Rehabilitation Engineer, and the Assistive Technology Instructor located in the District Offices.

PREPARED BY

DSB Vocational Rehabilitation (VR) Counselor or Independent Living Rehabilitation (ILR) Counselor

INSTRUCTIONS

Referral to: Enter the name of the AT staff person to receive the referral.

Date: Enter the two-digit month, two-digit day and four-digit year.

Referring Counselor: Enter the name of the DSB VR or ILR Counselor making the referral.

Office Location: Enter the District Office location.

Name: Enter the individual's name (first, middle initial and last name). All referrals must be applicants, active cases, or post-employment cases.

Phone: Enter the individual's home and work phone numbers with the area code and seven-digit number.

Address: Enter the individual's most current street address, city and five-digit zip code.

E-mail: Enter the individual's full e-mail address.

Technology Services Needed for: Place an X in the appropriate block to identify all reasons assistive technology services are needed by the individual.

Service Requested: Place an X in the appropriate block to identify the specific service requested are identified. More than one reason may be identified.

Technology will be located: Place an X in the appropriate block to identify the location of the technology: Individual's home, location of training or on the job.

If equipment will be located at the individual's home that is different from address listed under "address" on this form, enter the street address, city and five-digit zip code.

If equipment will be at location of training, enter the most current street address, city and five-digit zip code. Enter the two-digit month, two-digit day and four-digit year for date training begins.

If equipment will be located on the job, enter the most current street address, city and five-digit zip code. Enter the two-digit month, two-digit day and four-digit year for the date of employment.

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Individual: Place an X in the appropriate block to indicate information about the individual's current adaptive skills. Copies of assessments reports indicating the individual's level of skill are to be attached.

Reason for Referral: Indicate the specific reason for referral.

Individual currently owns/has access to the following equipment (include approximate age): Indicate the specific equipment currently owned and used by the individual. Indicate the year the equipment was purchased or an approximate age.

Previous AT Assessments/Training: Indicate all previous specific assessments and/or training.

Please attach: Copies of the most current information listed on the form. Attach a narrative description if needed to provide further information to the AT staff member to facilitate services to the individual. If the individual has residual vision, the individual must be assessed by the Nursing Eye Care Consultant (NECC) or Low Vision Program Specialist (LVPS) for ability to use optical or non-optical aids and techniques, and the DSB 2205-B Report or the LVPS report must be attached. If an Evaluation with Video Magnification (Closed Circuit Television), DSB 2007, has been completed by the NECC, LVPS, or AT Teacher at the Rehabilitation Center for the Blind, this must also be attached.

Referring VR or ILR Counselor signs the form.

Referring VR or ILR Counselor enters e-mail address.

DISTRIBUTION

Original: AT Staff Person
Copy: Case Record