Referral for Services Form

revised 6-2013

Virginia Commonwealth University

Participant ID #: _____

PERSONAL DATA

Date:

Provide the following information on the individual being referred.

Name: _____ SS#: _____
(last) (first) (MI)

Address: _____
(street) (city) (state) (zip code)

County: Phone: _____

Primary Care Giver: _____ Relationship: _____ Phone: _____

Address: _____
(street) (city) (state) (zip code)

DEMOGRAPHICS

Provide the following demographic information by completing the blank or selecting the appropriate answer for the following.

Sex: ☐ Male ☐ Female Date of Birth: _____ Age of Disability Onset: ____

Race: ☐ White ☐ African American ☐ Asian ☐ Hispanic ☐ Ethnic Origin Unknown

Has the individual been convicted of a felony or misdemeanor? ☐ Yes ☐ No

DIAGNOSIS

Categorize the person's diagnosis; specify dominance using: 1 (primary), 2 (secondary), etc.

☐ **Substance Abuse**

Developmental Disability

- ☐ Intellectual Disability
- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Spina Bifida

☐ **Epilepsy**

☐ **Deaf/Hard of Hearing**

☐ **Immune System Disorders**

☐ **Blind/Visual Impairment**

Neurological

- ☐ Traumatic Brain Injury (TBI)
- ☐ Anoxic Brain Damage
- ☐ Spinal Cord Injury (SCI)
- ☐ Stroke

Psychiatric

- ☐ Anxiety Disorders
- ☐ Bipolar
- ☐ Major Depression
- ☐ Personality Disorder
- ☐ Schizophrenia

Other Diagnosis (specify):

REFERRING AGENCY

Name: _____ Email address: _____

Address: _____
(street) (city) (state) (zip code)

Phone No.: _____ Fax No.: _____