NC Division of Vocational Rehabilitation Services and County Social Services Agency/Department Referral

Complete this form when referring an applicant/recipient/consumer for services.

Date: _____

To: *(circle one)* Social Services Agency Vocational Rehabilitation Services

From: *(circle one)* Social Services Agency Vocational Rehabilitation Services

I. Referring Agency Information:

Agency Name: _____ Date of Referral _____

Agency Contact Person: _____ Telephone No. _____

Email _____ **(Check all of the following that apply)**

☐ Contact for additional information ☐ Provide appointment date ☐ Notify if appointment missed

II. Participant/Consumer Information:

Name: _____ DOB. _ _ - _ _ - _ _ _ _

Mailing Address: _____
City State Zip Code

Telephone#: _____

Reason for Referral: _____

_____

_____

Consent for Release of Information Attached: Y / N (circle one)

III. Referral Feedback:

Agency Staff: _____ Telephone No._____

Email: _____

Original appointment date: _____ Status: as scheduled / no show / rescheduled *(circle one)*

Reschedule Date: _____ Additional Comments: _____

_____

_____

_____

_____

Signature of Agency Contact Position Date

The Department of Health and Human Services complies with Federal and State laws, which restrict the use and disclosure of information concerning applicants and recipients of public assistance and comply with applicable provisions of the Social Security Act concerning confidentiality. The Department of Health and Human Services does not discriminate against any person on the basis of race, color, national origin, sex, religion, age, political beliefs, or disability.