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: ____

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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: ___________________________________

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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.