Referral Form to Division of Vocational Rehabilitation Services (DVRS)

________________ Department of Social Services (DSS)

Date:____

DSS Contact Person:___________________________ Phone :___________________________

Email:_______________________________________ Fax:______________________________

Client Name:_________________________________ Phone:____________________________

Address:_____________________________________ Male______ Female______

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DOB:____

Reason for Referral:

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FEEDBACK FROM DVRS TO DSS

(*Please return this portion to DSS*)

Counselor's Name:_________________________ Date:__________________________________

Phone:__________________________________

Appointment Date:_________________________ Did the participant keep their appointment?

□ Yes □ No

Additional Comments:

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