

Virginia Department for Aging and Rehabilitative Services Division of Rehabilitative Services

MH Referral Form for Vocational Rehabilitation Program

Date _____	DRS VR Counselor _____	Caseload No _____
Referring Agency _____	Referral Source Code	3

Consumer Information

Social Security #* (If known) _____

Last Name* _____ First* _____ MI _____

Preferred Name _____ Gender* Male Female DOB _____

Home Address* _____

Primary Phone () _____ Voice TTY/Videophone Fax

Second Phone () _____ Voice TTY/Videophone Fax

E-Mail _____

Legal Eligibility To Work in the US? US Citizen Work Permit None Unknown

Workers' Comp SSI SSDI Claimant TANF Other _____

1. Diagnosis (DSM-IV):

Axis I Code No: _____ Description: _____

Axis II Code No: _____ Description: _____

Axis III Code No: _____ Description: _____

Axis IV Code No: _____ Description: _____

Axis V Code No: _____ Description: _____

2. Age of Onset _____

3. History of Psychiatric Hospitalizations

4. History of Therapy

5. **Work History** (Include any supported or transitional employment. Please include any problems that the client experienced on the job.)

6. **What is the client's expressed vocational goal? What does the client want to do? How many work hours per day? Work during the day or night? Work on weekends?**

7. **Do you think this is a realistic goal, and if not, what do you think would be appropriate?**

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8. Barriers to Employment *(Check all that apply.)*

- | | | | | | |
|-------------------------|--|---------------------|--------------------------|--------------------------|--------------------------|
| Auditory Hallucinations | <input type="checkbox"/> | Slurred Speech | <input type="checkbox"/> | Poor Concentration | <input type="checkbox"/> |
| Difficulty Getting Up | <input type="checkbox"/> | Paranoia | <input type="checkbox"/> | Poor Memory | <input type="checkbox"/> |
| Thought Disorder | <input type="checkbox"/> | Impulsive | <input type="checkbox"/> | Transportation Problems | <input type="checkbox"/> |
| Poor Hygiene | <input type="checkbox"/> | Irritable | <input type="checkbox"/> | Poor Problem Solving | <input type="checkbox"/> |
| Easily Angered | <input type="checkbox"/> | Poor Appearance | <input type="checkbox"/> | Inflexible | <input type="checkbox"/> |
| Easily Frustrated | <input type="checkbox"/> | Socially Isolated | <input type="checkbox"/> | Poor Coordination | <input type="checkbox"/> |
| Problems Taking Meds | <input type="checkbox"/> | Low Tolerance Level | <input type="checkbox"/> | Cognitive Deficits | <input type="checkbox"/> |
| Tactless | <input type="checkbox"/> | Poor Judgment | <input type="checkbox"/> | Difficulty with Feedback | <input type="checkbox"/> |
| Uncooperative | <input type="checkbox"/> | Easily Distracted | <input type="checkbox"/> | Insomnia | <input type="checkbox"/> |
| Other | <input type="checkbox"/> <i>(Specify):</i> _____ | | | | |

9. What does the client need in order to minimize employment barriers?

- | | | | | | |
|--------------------|--|-----------------------------|--------------------------|-----------------------|--------------------------|
| Therapy | <input type="checkbox"/> | Supportive Counseling | <input type="checkbox"/> | Medication Compliance | <input type="checkbox"/> |
| Career Exploration | <input type="checkbox"/> | Social Skills Training | <input type="checkbox"/> | Vocational Placement | <input type="checkbox"/> |
| Vocational Testing | <input type="checkbox"/> | Clubhouse Services | <input type="checkbox"/> | Volunteer/Unpaid Work | <input type="checkbox"/> |
| TEP | <input type="checkbox"/> | Further Educ/Training | <input type="checkbox"/> | Behavioral Contract | <input type="checkbox"/> |
| Videotaping | <input type="checkbox"/> | Med Management | <input type="checkbox"/> | Travel Training | <input type="checkbox"/> |
| Case Mngmnt Svs | <input type="checkbox"/> | Basic Work Readiness Skills | <input type="checkbox"/> | Medication Compliance | <input type="checkbox"/> |
| Other | <input type="checkbox"/> <i>(Specify):</i> _____ | | | | |

10. What supports does the client currently have?

- | | | | | | |
|-------------------|--|-----------|--------------------------|---------------|--------------------------|
| Family | <input type="checkbox"/> | Therapy | <input type="checkbox"/> | Residential | <input type="checkbox"/> |
| Case Management | <input type="checkbox"/> | Clubhouse | <input type="checkbox"/> | Day Treatment | <input type="checkbox"/> |
| Medication Clinic | <input type="checkbox"/> | | | | |
| Other | <input type="checkbox"/> <i>(Specify):</i> _____ | | | | |

11. Reason for Referral *(Please include the client's strengths.)*

12. Additional Comments

13. Signature

Psychiatrist (Print Name)	_____	Sign	_____	Date	_____
Therapist (Print Name)	_____	Sign	_____	Date	_____