## Adaptive Technology Evaluation Referral Form

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| Area Office: |  | | Date of Referral: |  |
| Counselor Name: |  | | Counselor Email: |  |
| VRCC Name: |  | | Email for Invoices: |  |
| Consumer Name: |  | | | |
| Client ID: |  | | Consumer Email: |  |
| Consumer Address: |  | | | |
| Primary Phone: |  | | Cell  Home  Other: | |
| Secondary Phone: |  | | Cell  Home  Other: | |
| Preferred Contact Method: | | Email  Phone Call (to Primary) Text Message (to Primary) | | |
| Specific Limitations to be considered in evaluation: | | | | |
|  | | | | |
| What is the Consumer’s Vocational Goal (if known)? | | | | |
|  | | | | |
| What are the Planned (or Anticipated) Primary Services (i.e. College, RBF, SBE)? | | | | |
|  | | | | |
| Is there a specific referral question you would like to have answered? | | | | |
|  | | | | |
| From what hardware and software vendors would you like quotes? | | | | |
|  | | | | |
| Other information that may assist in evaluation/scheduling of evaluation? | | | | |
|  | | | | |
| Collateral Attached:  Psychological Testing  Functional Capacity Evaluation  IEP/School Evaluation  Neuropsychological Testing  Other: | | | | |
| Authorization Attached  Yes  Will send at a later date (evaluation will not be scheduled without authorization in hand | | | | |

**Authorization should include:**

Assistive/Adaptive Technology (AT) Evaluation ($495 flat rate)

Travel ($74/hour, see travel estimate sheet or call for estimated hours)

**Please email completed form to** [**referrals@adaptiveenterprisesllc.com**](mailto:referrals@adaptiveenterprisesllc.com)