## 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**