State of Illinois
Department of Rehabilitation Services
REFERRAL CONTACT

Program (Check One): ___ VR ___ HSP ___ TLP ___ CSVH

Date	Method of Contact				
NAME LAST	FIRST	MIDDLE			
ADDRESS	CITY	COUNTY	STATE	ZIP	
TELEPHONE ( )	DATE OF BIRTH	AGE	SEX	SSN	HIGHEST GRADE
REPORTED DISABILITY PRIMARY:	SECONDARY:	VETERAN ___ YES ___ NO			
REASON FOR REFERRAL					
REFERRAL SOURCE	OTHER MEANS OF CONTACT				
SSDI STATUS APPLIED FOR ___ RECEIVING ___ DENIED ___	SSI STATUS APPLIED FOR ___ RECEIVING ___ DENIED ___				
EMPLOYMENT STATUS (IF APPLICABLE TO PROGRAM) UNEMPLOYED ___ EMPLOYED ___ FULL TIME ___ PART TIME ___ NEVER EMPLOYED ___ SELF EMPLOYED ___ STUDENT ___					

Appointment Information: Contact Client ___ Contact Referral ___	Appointment Scheduled ___ Date _____ Time _____ Location _____

Comments: _____

Referral taken by: _____ Date: _____

Referred to: _____ Dist: _____ Date: _____

(OVER FOR HSP PRESCREENING/REFERRAL INFORMATION)