Kentucky Office of Vocational Rehabilitation
Assistive Technology Referral Form

Referring Counselor: _____ **Date:** _____

Name: _____ **Case #:** _____ **Date of Birth:** _____

Address: _____

Phone: _____ **Email:** _____ **County:** _____

Disablity:

Prognosis: ◯ Stable ◯ Progressive ◯ Fluctuating ◯ Other: _____

Type of Consumer: ◯ General VR Services ◯ Independent Living ◯ Pre-ETS

Current Working Status: ◯ Employed ◯ Work Ready
◯ College &/or training ◯ College / training anticipated
◯ Planning Stage ◯ Other: _____

Anticipated Employment Date: _____

Vocational Goal or Major/Training Program or Job Title: _____

Mobility: ◯ Independent ◯ Walker / Cane ◯ Scooter ◯ Manual wheelchair
◯ Manual wheelchair with Power Assist ◯ Power wheelchair ◯ Other: _____

Specify model, year obtained, and funding source: _____

Level of Service Requested: ◉ Complete AT services ◯ Assessment ◯ AT Training
◯ Consultation ◯ Repair/Maintenace ◯ Other: _____

Type of Assistive Technology Services Requested: *Check all that apply.*

- ☐ Home Modification
- ☐ Work Accommodations
- ☐ Worksite Accessibility
- ☐ Work from Home
- ☐ School Accommodations
- ☐ Computer Hardware/Software Only
- ☐ Computer Access Only
- ☐ Mobility (wheelchair)
- ☐ Communication
- ☐ Independent Living
- ☐ Farm Modification
- ☐ Other: _____

Please provide a narrative description of the specific services requested.

Currently use AT? ◯ **Yes** ◯ **No** **Provider:** _____

Describe current assistive technology usage:

Assistive Technology Referral Form
Additional Information

Vision Information

Best Corrected Visual Acuity - Right Eye: _____ Left Eye: _____

Does the consumer currently use any low vision aids? ◯ Yes ◯ No

List current low vision aids, including type, model, and year purchased.

Indicate if the consumer has had the following evaluations and include the reports:

- ☐ Low vision
- ☐ Visual fields
- ☐ Bioptic driving
- ☐ Other: _____

Education Information

School: _____ Start Date: _____

Has the Student contacted disability services? Yes ◯ No ◯

List approved accommodations:

Indicate if the consumer has had the following evaluations / plans and include the reports:

- ☐ IPE/Section 504 plan
- ☐ Neuropsych Evaluation
- ☐ Post-Secondary Accommodations Plan
- ☐ Other: _____

Independent Living

Please describe any previous IL training/services received.

Other Professional

Please provide contact information for other professionals who should be involved in the AT assessment process (i.e. supported employment providers, placement specialist, job coach, employer, etc.).

Name _____

Role _____

Organization _____

Phone _____

Email _____