Reset Form Print Form

OVR-120-A
Rev. 10/13

DEPARTMENT OF LABOR & INDUSTRY
OFFICE OF VOCATIONAL REHABILITATION

REFERRAL INFORMATION/OFFICE MESSAGE

*Social Security Number: Date:

*Name: (Last) *(First) (MI)

*Address:

*City: *State: *Zip Code: *County:

*Phone #: *Birth Date: (mo/day/yr) *Gender: ☐ Male ☐ Female

*Referral Source: ☐ American Indian VR Services Program ☐ Centers for Independent Living
☐ Child Protective Services ☐ Community Rehabilitation Programs ☐ Consumer Organizations or Advocacy Groups
☐ Educational Institutions (elementary/secondary) ☐ Educational Institutions (post-secondary) ☐ Employers
☐ Family/Friends ☐ Intellectual and Developmental Disabilities Providers ☐ Medical Health Provider (Public or Private)
☐ Mental Health Provider (Public or Private) ☐ One-stop Employment/Training Centers ☐ Public Housing Authority
☐ Self-referral ☐ Social Security Administration (Disability Determination Service or District office)
☐ State Department of Correction/Juvenile Justice ☐ State Employment Service Agency ☐ Veteran's Administration
☐ Welfare Agency (State or local government) ☐ Worker's Compensation ☐ Other Sources
☐ Other State Agencies ☐ Other VR State Agencies

*Expansion Referral Source & Code:

*Referral Source Phone Number: * Township:

*District Name/Number: * Counselor Name/Number:

*Program: ☐ SS-A ☐ SS-C ☐ IL ☐ VR ☐ Special Needs

☐ Special Needs: ☐ Disability:

Services Requested/Comments:

This form completed by

*DESIGNATES REQUIRED FIELDS