



# Pre-ETS Referral Form

\*Required Fields

## Student Information

\*Name: \_\_\_\_\_ SS#: \_\_\_\_\_

\*Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Disability Documentation: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

\*Home address: \_\_\_\_\_

\*City: \_\_\_\_\_ \*Zip Code: \_\_\_\_\_ \*County: \_\_\_\_\_

\*Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

\*Name of School: \_\_\_\_\_

**Parent/Guardian Information (if applicable) Name:** \_\_\_\_\_

Home Phone, if different from student: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

## \*Agency Making Referral

Name: \_\_\_\_\_ Position: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

## Accommodations for initial meeting with VR Staff:

Do you require an American Sign Language interpreter?  Yes

Do you require an assistive listening device?  Yes

Do you require translated documents?  Yes

Do you require a foreign language interpreter?  Yes

Do you require any other accommodation for your impairment?  Yes

*If yes, please explain:* \_\_\_\_\_

## \*Transition Youth Services Requested (Check all that apply)

Job Exploration Counseling (includes discussions on the student's vocational interests, the labor market, and identification of career pathways)

Work Readiness Training (A 20 hour course that focuses on employability and work readiness skills)

Self-Advocacy Training (A course that teaches students how to speak up for themselves and make decisions about their own lives)

Postsecondary Educational Counseling (provides an awareness of post-secondary career pathway options with job and career information) \* Service is not currently available

Work-Based Learning Experiences (includes hands on training for employability skills; may be paid or non-paid)

## Student Acknowledgement

**I understand that through Vocational Rehabilitation, I will be offered limited Pre-Employment Transition Services that can help me explore, prepare for, and make informed career-based decisions. I understand that I must be an active participant in the services I choose to achieve my transition goals.**

\_\_\_\_\_ Signature of Student \_\_\_\_\_ Date \_\_\_\_\_



## Permission to Make Referral

**By Signing this Pre-ETS Referral, I give \_\_\_\_\_ permission to submit this Pre-ETS Referral to VR. I understand I will be contacted by VR Staff to set up an initial meeting and acknowledge that my participation is required if my child is under 18 or if I am his/her Guardian.**

Parent/Guardian/Age of Majority Student: \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_



Referral Staff: \_\_\_\_\_ Printed Name \_\_\_\_\_ Position \_\_\_\_\_  
 \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**Name of person submitting the Pre-ETS Referral to VR: \_\_\_\_\_ Phone # of person submitting the referral to VR (if different): \_\_\_\_\_**

**For Official VR Use Only (to be completed by VR Staff)**

VR Staff Name: \_\_\_\_\_ Area/Unit \_\_\_\_\_

Date referral received: \_\_\_\_\_ Date entered into RIMS: \_\_\_\_\_