LOUISIANA TECH UNIVERSITY
CENTER FOR REHABILITATION ENGINEERING, SCIENCE & TECHNOLOGY

Date Referred: ________________

REFERRAL FORM

Date Received: ________________

Please help us in our efforts to expedite the referral process and provide better service to your Consumer by providing all of the information requested below.

Consumer's Name____ Date of Birth __________________________

Address ____________________________________ City _________________ State _______ Zip _________

Home Phone #____________________ Cell Phone #_________________ Work Phone # ________________

Sex ______ Race _______ Consumer email: ____

Does Consumer have a legal guardian? ______ If yes, give name & address ___________________________

____

* * * * * * * * * * * * *

Counselor's Name/District Office____

Address ____

Counselor's Phone #______________________________ Counselor's FAX #_________________________

Counselor's Email _____________________________@lwc.la.gov___________________________________

* * * * * * * * * * * * * *

Physician's Name____ Phone #_______________________

Address____

Primary Disability____

Date of Onset _______________ Secondary Disability (If applicable) __________________________________

Current Medication(s)____

* * * * * * * * * * * * * *

Center Service(s) requested:

____ **Assistive Devices for Independent Living**

____ **Augmentative/Alternative Communication**

____ **Computer Access**

Personal Transportation

____ Driver Assessment

____ Transportation Only

Rehabilitation Engineering

____ Home Assessment

____ Worksite Assessment

____ **Seating & Wheeled Mobility**

____ **Blind/Low Vision** (North LA Only)