

LOUISIANA TECH UNIVERSITY
CENTER FOR REHABILITATION ENGINEERING,
SCIENCE & TECHNOLOGY

REFERRAL FORM

Date Referred: _____

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 _____ @dss.state.la.us

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**

____ **Rehabilitation Engineering**

____ **Seating & Wheeled
Mobility**

____ Driver Assessment

____ Home Assessment

____ Transportation Only

____ Worksite Assessment