N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND
VOCATIONAL REHABILITATION

REFERRAL FOR ASSISTIVE TECHNOLOGY SERVICES

Referral to: _____ *Date*: _____

Referring Counselor: _____ *Office location*: _____

Name: _____ **Phone:** _____

Address: _____ **E-mail:** _____

_____

Technology Services needed for: Employment ☐ School/Training ☐ Job Development ☐
Independent Living ☐ Res. Modification ☐ BE Operator ☐

Service Requested: Assessment ☐ Set-up ☐ Follow-up ☐ Other ☐

Technology will be located: In Individual's Home ☐ _____ (*address*)

At location of training ☐ _____ (*address*) Date Training Begins _____

On the Job ☐ _____ (*address*) Date of Employment _____

Individual: Is a Braille reader ☐ Uses Large Font (size) ☐ Reads regular print ☐
Requires speech adaptation ☐
Has been assessed by NECC/Low Vision Program Specialist to determine that optical/ non-optical will not meet required functional needs (for CCTV services) ☐

Reason for Referral: _____

_____

Individual currently owns/has access to the following equipment (*include approx. age****)***:

_____

Previous AT Assessments/Training: _____

_____

Required Attachments:

1. Copy Vocational Rehabilitation or ILR Application and IPE or ILP with Amendments
2. Most recent eye information
3. Copies of available reports from Evaluation Unit and/or Rehabilitation Center
4. Copy of low vision evaluation (DSB-2205-B or Low Vision Program Specialist report) for CCTV or screen magnification services.
5. Any technology or skill level assessment and training reports
6. DSB-0197 Request for Resident Modification form for home modifications

_____
Signature of DSB VR Counselor or ILR Counselor

EMAIL ADDRESS _____