ODMHSAS IPS Contractor
Referral to DRS for Individual Placement Supports (IPS)

Customer has identified disability barriers to applying, interviewing, accepting or maintaining employment and wants to become employed.

Referring Staff: ____________________ (   ) ____________________

First MI Last, Suffix, if applicable | Phone | Email | Date of Referral

Customer: ____

First | Middle | Last | Suffix | Date of Birth

(   ) ____________ (   ) ____________ ____________________

Home Telephone | Cell Phone | E-mail

____

Address | City | State | Zip Code

Guardian, if applicable: ____________________ (   ) ____________

First MI Last, Suffix, if applicable | Relationship | Telephone, including area code

Guardian E-Mail: ____________________

What services may you need from DRS?

- ☐ **Individual Placement Supports**
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

Include copies of at least one of the following with referral packet:

- ☐ Psychiatric Assessment
- ☐ Psychological testing results, if available
- ☐ Treatment Notes and/or Individual/Family Psychosocial Assessment

Also provide a copy of the Career Profile, if completed prior to referral.

HEALTH QUESTIONS

A. **Please list any additional disabilities you are or have been treated for:**

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B. What medications are you taking currently?

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______________________________ ______________________________
______________________________ ______________________________
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C. **Do you have any other medical concerns?**

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D. Check any of the following that you cannot do because of your disability:

- ☐ 1. Bending
- ☐ 2. Climbing
- ☐ 3. Concentration
- ☐ 4. Crawling
- ☐ 5. Grasping
- ☐ 6. Handle stress
- ☐ 7. Hearing
- ☐ 8. Keeping my balance
- ☐ 9. Kneeling
- ☐ 10. Learning
- ☐ 11. Lifting
- ☐ 12. Making Change
- ☐ 13. Memory
- ☐ 14. Operating Machinery
- ☐ 15. Pulling
- ☐ 16. Pushing
- ☐ 17. Reading
- ☐ 18. Sitting
- ☐ 19. Speaking
- ☐ 20. Spelling
- ☐ 21. Squatting
- ☐ 22. Standing
- ☐ 23. Vision
- ☐ 24. Walking
- ☐ 25. Work around people
- ☐ 26. Work full-time
- ☐ 27. Work where it's cold
- ☐ 28. Work where it's dusty
- ☐ 29. Work where it's humid
- ☐ 30. Writing
- ☐ 31. Other:____

E. Are you medically cleared to work? .... ☐ Yes ☐ No
If yes, do you have any restrictions or limitations? .... ☐ Yes ☐ No

List the # from D above, What restrictions:	**List the # from D above, What restrictions**
______________________________	______________________________
______________________________	______________________________
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F. Do you have an active Workers Compensation or Auto No-Fault case? .... ☐ Yes ☐ No