ESS Assessment Referral

Clear Form

Referral to (Contractor): _____

Individual's Name: _____

Address: _____ OK _____
Street Address *City* *State* *Zip Code*

Home Phone: _____ Cell Phone: _____

Date of Birth: _____
mm/dd/yy

Primary Disability: _____

Secondary Disability: _____

DRS Counselor Name: _____

Address (Office): _____ OK _____
Street Address *City* *State* *Zip Code*

Phone: _____ Fax: _____

Type of Assessment Needed (Check all that apply):

- ☐ **ESS-C-353-1** — Cognitive
- ☐ **ESS-C-353-2** — Communication
- ☐ **ESS-C-353-4** — Daily Living
- ☐ **ESS-C-353-5** — Housing
- ☐ **ESS-C-353-6** — Mobility
- ☐ **ESS-C-353-7** — Tolerance
- ☐ **ESS-C-353-8** — Transportation
- ☐ **Other:** (Write comment below.)

Describe any problems the individual is having in the above assessment areas:

DRS Counselor Name: _____ Date: _____

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