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| Texas Workforce Solutions logo | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Referral for Career Planning Assessment** | |
| **Provider Selected** | | |
| **Provider name:** | | **Referral date:** |
| **Service Premiums (if any):**  Autism Brain Injury Deaf Other: | | |
| **Customer Information** | | |
| **Customer name:** | | **Case ID:** |
| **Language preference:** | | **Date of birth:** |
| **Address:** | | |
| **Phone (if any):** (   ) | | **Email (if any):** |
| **Alternate contact name (if any):** | | **Relation:** |
| **Alternate contact phone (if any):** (   ) | | **Alternate contact email (if any):** |
| **Customer’s reported disabilities:** | | |
| **VR Contact Information** | | |
| **Counselor name:** | | |
| **Counselor phone:** (   ) | | **Counselor email:** |
| **Rehabilitation Assistant (RA) name:** | | |
| **RA phone:** (   ) | | **RA email:** |
| **VR office name:** | | |
| **Attachments** (as applicable) | | |
| Benefits reports (BPQY, BSA/WIP) | | School records |
| Case notes | | Service authorization |
| Individualized Plan for Employment (IPE) | | VR3472 |
| Medical and/or psychological records | | Waiver Plan |
| Other attachment(s): | | |
| **Comments, Concerns, and Questions** | | |
| **Additional comments, concerns, or questions for this referral (if any):** | | |