



THE CULINARY SCHOOL

Referral

Please email to lgrinnage@fbd.org or fax to (302) 292-1309

Please complete the following information on the individual being referred: DVR and OVR counselors should include a recent Medical or Psychological Report and Discharge Summary (if individual has been institutionalized) and provide list of previous criminal charges if applicable.

CONSUMER INFORMATION:

Date of Referral: _____

Name: _____ Birth Date: _____

Social Security #: _____ Home Phone: _____ Cell Phone: _____

Mailing Address: _____

Residential Address: _____

REFERRAL INFORMATION:

Referral Agency: _____ Referring Counselor: _____ Phone: _____

Reason for Referral: _____

Functional Limitations: _____

1. Primary Disability: _____

2. Secondary Disability: _____

3. Other Disability: _____ Severely Disabled? ___ Yes ___ No

Please check the disadvantages that apply: () Vocational () Economical () Educational () Other

Does this person have the 9th grade reading level required for the program?



Individual's Name: _____

Birth Date: _____

DEMOGRAPHIC INFORMATION:

Please check items from each category that are appropriate. **All sections must be completed.**

Sex: ___ Male ___ Female	Veteran: ___ Yes ___ No ___ Vietnam Era ___ Special Disabled	Annual Household Income: ___ \$0 - \$5,000 ___ \$5,000-\$7,999 ___ \$8,000-\$9,999 ___ \$10,000-\$14,999 ___ \$15,000-\$19,999 ___ \$20,000-\$39,999 ___ \$40,000- \$49,999 ___ \$50,000 +	Educational Status: ___ H.S. Dropout ___ Less than H.S. ___ H. S. Graduate ___ GED ___ Post H.S. ___ College Graduate ___ Post College ___ Special Education
Marital Status: ___ Single ___ Married ___ Separated ___ Divorced	Transportation: ___ Bus ___ Own Auto ___ Paratransit ___ Public ___ Special Vehicle	Ethnic Group: ___ American Indian ___ Asian ___ Black ___ Hispanic ___ White	Family Status: ___ Single Parent ___ Teenage Parent ___ Two Parent Family ___ Other Family Member
U. S. Citizen: ___ Yes ___ No	Labor Force Status: ___ Employed ___ Unemployed ___ Under Employed ___ Other		
Living Arrangements: ___ Supervised ___ Monitored ___ Independent ___ Transitional			

Support: ___ SSDI ___ SSI ___ Own Earnings ___ Family ___ Food Stamps ___ General Assistance ___ Welfare ___ Workman's Compensation ___ Other

Criminal History:

Charges _____ Date of Charge: _____
Charges _____ Date of Charge: _____

REFERRAL/PREVIOUS REHAB SERVICES INFORMATION:

Please check or fill in appropriate areas:

___ Prior Institutionalization ___ History of Substance Abuse ___ Public Offender ___ Receiving Mental Health Services

Prior Rehab Agencies Attended:

Name: _____ Start Date: _____ End Date: _____ Program _____ Completed: Y N
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Counselor Signature

Date