THE CULINARY SCHOOL

Referral
Please email to lgrinnage@fbd.org

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

Marital Status:
____ Single
____ Married
____ Separated
____ Divorced

U. S. Citizen:
____ Yes
____ No

Living Arrangements:
____ Supervised
____ Monitored
____ Independent
____Transitional

Veteran:
____ Yes
____ No
____ Vietnam Era
____ Special Disabled

Transportation:
____ Bus
____ Own Auto
____ Paratransit
____ Public
____ Special Vehicle

Labor Force Status:
____ Employed
____ Unemployed
____ Under Employed
____ Other

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 +

Ethnic Group:
____ American Indian
____ Asian
____ Black
____ Hispanic
____ White

Educational Status:
____ H.S. Dropout
____Less than H.S.
____H. S. Graduate
____ GED
____Post H.S.
____ College Graduate
____ Post College
____ Special Education

Family Status:
____ Single Parent
____ Teenage Parent
____ Two Parent Family
____ Other Family Member

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
Name: _____ Start Date: _____ End Date: _____Program _____ Completed: Y N
Name: _____ Start Date: _____ End Date: _____Program _____ Completed: Y N

_____ _____
Counselor Signature **Date**