GOVERNMENT OF
THE VIRGIN ISLANDS
DEPARTMENT OF HUMAN SERVICES
VOCATIONAL REHABILITATION PROGRAM
DIVISION DISABILITIES & REHABILITATION SERVICES

No. 2 Estate Carlton, Suites 4 & 7
Frederiksted, VI 00840
(Tel.) 340-643-8145
(Tel.) 340-626-6268

Knud Hansen Complex
1303 Hospital Ground, STE. 1
St. Thomas, V.I. 00802-6722
(Tel.) 340-774-0930
(Fax) 340-774-7773

Referral Information

☐ Vocational Rehabilitation
☐ Independent Living
☐ Pre-Employment Transition Services

Name: ______________________________ Sex ______ Social Security No.______________________________

Date of Birth _________________ Age _______ Place of Birth _________________________________________

Citizenship Status ___________________ Alien Regis. No. ______________Occup. ________________________

Home Address _________________________________ Mailing Address_________________________________

Tel. No. Work _____________ Home______________ Cell ____________________Email___________________

Person to notify of emergency____________________________________________________________________

Referred By __________________________________ Date of referral __________________________________

Statement of Disability __________________________________________________________________________

Type of service requesting________________________________________________________________________

Social Security Beneficiary No____ Yes____ Workman's Compensation______________________

Medical Assistance No____ Yes____ Card Number ________________________________

Health Insurance No____ Yes ____ Name of Company (ies) _______________________

Public Assistance No____ Yes ____ Type of Service _____________________________

Name & Address of client Physician _______________________________________________________________

Name & Address of referral source or organization____________________________________________________

* Professional personnel referring client, when possible please obtain release from client or guardian attach pertinent medical, psychiatric, psychological, or education information.

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**FOR VOCATIONAL REHABILITATION USE ONLY**

| Referral Taken by: | Assigned to: | Date: |
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Note to counselor: As a professional courtesy to doctors, professional service workers, agencies or organization making referral, please fill out and send to "Report Back to Referral Source" form at the end of the evaluation process.