ODMHSAS IPS Contractor
Referral to DRS for Individual Placement Supports (IPS)

Customer has identified disability barriers to applying, interviewing, accepting or maintaining employment and wants to become employed.

Referring Staff:_____ (___)_____ _____ _____
  First MI Last, Suffix, if applicable   Phone   Email   Date of Referral

Customer:_____ _____ _____
    First   Middle   Last   Suffix   Date of Birth

(___)_____ (___)_____ _____
Home Telephone   Cell Phone   E-mail

_____ _____ _____ _____
Address   City   State   Zip Code

Guardian, if applicable:_____ (___)_____
        First MI Last, Suffix, if applicable   Relationship   Telephone, including area code

Guardian E-Mail:_____

What services may you need from DRS?

- ☐ **Individual Placement Supports** _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Include copies of at least one of the following with referral packet:

- ☐ Psychiatric Assessment
- ☐ Psychological testing results, if available
- ☐ Treatment Notes and/or Individual/Family Psychosocial Assessment

Also provide a copy of the Career Profile, if completed prior to referral.

HEALTH QUESTIONS

A. Please list any additional disabilities you are being or have been treated for:

_____
_____
_____
_____
_____
_____
_____
_____

B. What medications are you taking currently?

_____   _____
_____   _____
_____   _____
_____   _____
_____   _____
_____   _____
_____   _____
_____   _____

C. Do you have any other medical concerns?

_____
_____
_____
_____
_____
_____
_____
_____
_____

D. Check any of the following that you cannot do because of your disability:

- ☐ 1. Bending
- ☐ 2. Climbing
- ☐ 3. Concentration
- ☐ 4. Crawling
- ☐ 5. Grasping
- ☐ 6. Handle stress
- ☐ 7. Hearing
- ☐ 8. Keeping my balance
- ☐ 9. Kneeling
- ☐ 10. Learning
- ☐ 11. Lifting
- ☐ 12. Making Change
- ☐ 13. Memory
- ☐ 14. Operating Machinery
- ☐ 15. Pulling
- ☐ 16. Pushing
- ☐ 17. Reading
- ☐ 18. Sitting
- ☐ 19. Speaking
- ☐ 20. Spelling
- ☐ 21. Squatting
- ☐ 22. Standing
- ☐ 23. Vision
- ☐ 24. Walking
- ☐ 25. Work around people
- ☐ 26. Work full-time
- ☐ 27. Work where it's cold
- ☐ 28. Work where it's dusty
- ☐ 29. Work where it's humid
- ☐ 30. Writing

☐ 31. Other:_____

E. Are you medically cleared to work?.. ☐ Yes ☐ No

   If yes, do you have any restrictions or limitations? .... ☐ Yes ☐ No

   List the # from D above, What restrictions: **List the # from D above, What restrictions**

   _____   _____
   _____   _____
   _____   _____
   _____   _____
   _____   _____
   _____   _____

F. Do you have an active Workers Compensation or Auto No-Fault case?....... ☐ Yes ☐ No