

Section 8 / Part 5
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Assessment Referral

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Assessment Referral

SRS Referring Office: _____
Address: _____
Case Manager Name: _____
Case Manager Phone: _____

Provider Name: _____
Provider Address: _____

Consumer Name: _____
Phone Number: _____
SSN: _____
Date of Birth: _____ Gender: _____
KAECSES Case #: _____
Medical ID#: _____

This person is being referred to you for more information regarding his/her ability to work or participate in work-related activities. Please bill the local SRS office at the address listed above, **Attention:** _____.

This referral is for:

- ___ Vocational Assessment
- ___ Psychological Evaluation
- ___ Psychological Evaluation with LD Evaluation
- ___ LD Evaluation
- ___ Medical Resolution
- ___ Other _____
- ___ Other _____

I have included records from:

- ___ Vocational Assessment/CDC dated _____
- ___ Psychological Evaluation
- ___ Psychological Evaluation with LD Evaluation
- ___ LD Information
- ___ Medical Providers
- ___ Definitive Medical Report
- ___ CASAS Appraisal/Diagnostic Results
- ___ SASSI Results
- ___ KAECSES/CAP 1
- ___ EES Initial Assessment Information
- ___ Other _____

REPORT: The intent of this referral is to help identify work options and specific plans to achieve those options. Include all applicable results in your response, including tools used, functional limitations and capabilities, vocational options, specific accommodations to maximize ability to work, local labor market options, transferable work skills, referral to other services, and specific recommendations. In addition, please address the following questions.

- 1.
- 2.
- 3.

Case Manager Signature: _____ **Date of Referral:** _____

cc: case file