



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

3011 Golden Rock C'sted  
Croix, V.I. 00820-4355  
(Tel.) 340-773-2323  
(Fax) 340-773-3641

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.

**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.

DRS-VR 05-2017  
Referral Form