***GVRA Service Referral Form***

**(Please Type the Information)**

**Client Name: Date of Birth: School:**

**Client Contact Number: Client Email Address:**

**Parent(s)/Guardian Name:**

**Parent(s)/Guardian Contact Number: Alt Number:**

**Parent(s)/Guardian Email Address:**

**Home Address:**

**Referring County Location: City Location of Client:**

 **Supported Employment**

 **Job Coaching # of hours # of days**

**Focus Area(s) for Service Selected:**

**Counselor’s Name: Phone Number: Fax Number:**

**Email Address:**

**Counselor Assistant’s Name: Phone Number: Fax Number:**

**Email Address:**

**Client Information**

1. **What is(are) the client’s disability(ies)?**
2. **What are the functional limitations impacting employment? (Physical stamina, emotional stability, standing, lifting, etc.) Describe.**
3. **Adverse side effects to medications? Yes No**

**If so, describe.**

1. **Any other concerns related to the disability and employment? Yes No**

**If so, describe.**

1. **Does individual have an IEP? Yes No If yes, please provide a copy with referral.**
2. **Does individual have access to public transportation? Yes No**
3. **Does the individual have other conditions that would impact services?**

 **Yes No (child care, criminal background, other diagnoses, etc)**

**Explain:**

**Any additional information:**

**\*\*This form along with the GVRA Authorization are both necessary before beginning services with Cultivating Growth. Please submit both via email to** **info@cgevolution.com**

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**Counselor Signature Date**