

# SCREEN FOR NEED OF VOCATIONAL REHABILITATION



Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Education: (Highest Grade Completed) \_\_\_\_\_ Occupation \_\_\_\_\_

Do you have a medical condition which limits work? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever lost a job due to your medical condition? Yes \_\_\_\_\_ No \_\_\_\_\_

Current Employment Status: Retired \_\_\_\_\_

Fully Employed \_\_\_\_\_

Under Employed \_\_\_\_\_

Part Time \_\_\_\_\_

Unemployed \_\_\_\_\_

Are you interested in gaining employment? Yes \_\_\_\_\_ No \_\_\_\_\_

**X** \_\_\_\_\_ Date \_\_\_\_\_

Patient's Signature

*Do not write below this line.*

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For office use only

Vocational Referral \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Vocational consultant's signature

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Patient was educated regarding availability of Vocational Rehabilitation Services through South Dakota Vocational Rehabilitation. A brochure was offered/provided to patient regarding how to contact South Dakota Vocational Rehabilitation.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature