The San Diego Community College District - Disability Support Programs and Services
3375 Camino del Rio South, Suite 275, San Diego, CA 92108
Phone: (619) 388-6984 Fax:(619) 388-6534

REFERRAL TO WORKABILITY III

*** UNDER SPECIAL PROGRAMS PLEASE CODE WA III AS THE PRIMARY CONTRACT FUND SOURCE ***

CONSUMER'S NAME: _____

ADDRESS: _____ CITY: _____ ZIP: _____

PHONE: _____ DATE OF BIRTH: _____ SEX: _____

EMAIL: _____

DISABILITY/DISABILITIES: _____

IMPAIRMENTS/RESTRICTIONS: _____

IPE GOAL (if written): _____

CONSUMER NEEDS VOCATIONAL EXPLORATION/PLAN DEVELOPMENT: ☐YES ☐NO

IS CONSUMER CURRENTLY A SDCCD STUDENT? ☐YES ☐NO CAMPUS: _____

IS CONSUMER IN DOR JOB CLUB? ☐YES ☐NO

BEFORE INITIAL APPOINTMENT IS SCHEDULED, ALL **REQUIRED** DOCUMENTS MUST BE SUBMITTED:

☐ **IPE** (If written)
☐ **HEALTH QUESTIONAIRE**
☐ **CLIENT CASE NOTES** (INTAKE INTERVIEW)
☐ EMPLOYMENT RECORD (OPTIONAL)
☐ **DOR** - **MEDICAL RELEASE FORM**
☐ PSYCHIATRIC EVALUATION (IF APPLICABLE)
☐ **DOR - NON MEDICAL RELEASE FORM**
☐ VOCATIONAL EVALUATION (IF APPLICABLE)
☐ **WORKABILITY III REFERRAL FORM**

IS CONSUMER CURRENTLY RECEIVING EMPLOYMENT SERVICES FROM ANY OTHER AGENCY? ☐YES ☐NO
IF YES, PLEASE LIST:

REFERRING COUNSELOR: _____ DATE: _____

SDCCD Release of Information

I authorize the Department of Rehabilitation to release/obtain to/from designated WorkAbility III Staff, my employment records, my medical records, and any other specified information on this form. I understand that this information is confidential and will be used only for the purpose of vocational evaluation and other vocational services, which may include: job assistance, worksite monitoring, and other related services as directed and approved by the vocational rehabilitation counselor. This consent applies until the plan completion date:_____ or until I specifically withdraw my consent.

Consumer Signature	Date	DOR Counselor Signature	Date