OVR

(rev. 01/2024)

Kentucky Office of Vocational Rehabilitation

Deaf-Blind Services Referral

Kentucky Career Center Vocational Rehabilitation

1. Consumer Information

Name					
Case Number	Consumer Type		Date of Birth *(MM/DD/YYYY)*		
Address					
City				State	Zip Code
Cell Phone	Home Phone	Email Address			
Emergency Contact Name			Emergency Contact Phone Number		

2. Other Service Providers

Please provide contact information for other service providers who should be involved in the services requested (i.e., job placement providers, employer, etc.)

1. Name		
Title		Organization
Phone	Email	
2. Name		
Title		Organization
Phone	Email	

3. Deaf-Blind Services

Has the Consumer received previous Deaf-Blind Services? *(If yes, please provide estimated dates of services and a description of services received)*

What are the current Deaf-Blind needs of this individual?

What is the preferred method(s) of communication?

Hearing *(Select all that apply)*

Verbal	American Sign Language (ASL)	Tactile ASL
Verbal with Assistive Listening Device	Up Close ASL	Other

If Verbal with Assistive Listening Device OR Other checked, please describe

Visual *(Select all that apply)*

Standard Print	Braille
Large Print	Other

If other checked, please describe

4. Disability Information

Does the consumer have a secondary disability which impacts their ability to participate in services? *(If yes, please explain)*

Please provide details of Visual Impairment and devices accommodations needed. *(i.e., assistive technology, service animal, etc.)*

Please provide details of Hearing Impairment and devices/accommodations needed. *(i.e., hearing aid(s), amplification, interpreter, etc.)*

Does the Consumer have a Mental Health diagnosis? *(If yes, please indicate where to locate supporting documentation in CMS, including folder and document title.)*

Has the Consumer received counseling for diagnosis or adjustment? *(If yes, please indicate where to locate supporting documentation in CMS, including folder and document title.)*

Do you have any safety concerns regarding the Consumer's past or current behavior? *(If yes, please describe.)*

5. Medical Information

Is the consumer diabetic?	**If yes, are they insulin dependent?**

Does the consumer take any medications? *(If yes, please send complete medication list with application)*

Please explain any other current or past medical conditions that the Deaf-Blind Coordinator needs to be aware of

6. Previous Assessments

Has the Consumer had any of the following assessments previously completed?

(Select all that apply. Reports should be available in CMS

Assistive Technology	IPE/504 Plan	Vision Acuity
Audiology	Orientation & Mobility	Vision – Visual Fields
Bioptic	McDowell Center	Other
CDPVTC Services	Neuropsychological	
Independent Living	Post Secondary	

If other, please specify