TLC/OUTCOMES

**EDS/WAT Referral Form**

**Please check service requested below:**

**In-person WAT**       **Virtual EDS**       **RISE-UP**

|  |  |  |  |
| --- | --- | --- | --- |
| **Counselor name:** |       | **Date:** |       |
| ***CONSUMER CONTACT INFORMATION*** |
| **Name:**  |       | **Age/DOB:** |       |
| **Address:** |       |
| **City:** |       | **State:** |       | **Zip:** |       |
| **Home phone:** |       | **Cell:** |       | **Email:** |       |
| ***ALTERNATE CONTACT PERSON*** |
| **Name:** |       | **Relationship:** |       | **Phone:** |       |
| **Primary Disability:** |       |
| **Primary impact of disability:** |       |
| **Does the consumer require any accommodations? If yes, list below.** |
|       |
| **Why is the consumer being referred for EDS? What specific behaviors need to be addressed?** |
|       |
| **Is consumer currently on medication? If yes, what medication and how does it impact the consumer?** |
|       |
| **What is the consumer’s employment goal based on the DORS IEP?** |
|       |
| **Is the consumer able to attend EDS daily (Monday – Thursday). If no, list days consumer can attend.** |
|       |
| **Does consumer have transportation or transportation funds to/from TLC Outcomes?** |
|       |
| **Please provide any other information that you think will help us to assist your consumer:** *Please forward pertinent info/reports (such as psych eval, voc eval, IPE, medical, work history info, Schedule A/B letter (if applicable) and if available, resume). A Purchase Order (PO) will be required to provide services.* |
|       |
| **You may email, fax, or mail this form/information** to TLC/Outcomes. **Email is preferred.**  |
| **Email**: dors@ttlc.org **Mail:** TLC/Outcomes, 1390 Piccard Drive, Suite 210, Rockville, MD 20850, **Fax:** 301-294-9209. |
| **For more information** contact Karen Morgret at (301) 294 – 9205 x 297.  |