Maryland State Department of Education
Division of Rehabilitation Services
Workforce & Technology Center

Pre-Admission Conference Report

Center counselors or case managers complete this form to document the pre-admission conference meeting held with a consumer in preparation for their admission to WTC.

Name: _____ **DORS PID:** _____

Center Counselor/Case Manager: _____ **Field Counselor:** _____

Residency: ☐ Day ☐ Dorm **Projected Admission Date:** _____

Projected Discharge Date and Plan:

_____
_____
_____
_____
_____

Goals:

_____
_____
_____
_____
_____

Disabilities:

_____

Services on the Authorization:

_____
_____

Self-Reported Barriers to Employment:

_____
_____

Areas Reviewed at Conference: (check box and add additional information as desired)

☐ WTC Rules & Regulations: _____
☐ Rights & Responsibilities: _____
☐ Behaviors: _____
☐ Schedule: _____
☐ Education: _____
☐ Work and Volunteer History: _____
☐ Transportation: _____
☐ Living Situation/Family Info: _____
☐ Childcare Arrangements: _____

Self-Report Survey

Health

1. Do you take medication? ☐ Yes ☐ No
   - Do you take your medication independently? ☐ Yes ☐ No
   - Do you need to be reminded to take your medication? ☐ Yes ☐ No
   - Dorm students: Do you have a daily medication cassette/pillbox at home? ☐ Yes ☐ No
2. Do you have allergies? ☐ Yes ☐ No
   - If yes, what are you allergic to? _____
   - If yes, do you have an EpiPen? ☐ Yes ☐ No
3. Do you have seizures? ☐ Yes ☐ No
   - When was the last one? _____
   - How often do you have them? _____
   - Please describe what happens when you have a seizure:

     _____
   - What do you want us to do if you have a seizure?

     _____
4. Do you have Diabetes? ☐ Yes ☐ No
   - Do you take insulin? ☐ Yes ☐ No
   - Is it on a sliding scale? ☐ Yes ☐ No
   - Are you able to calculate your sliding scale? ☐ Yes ☐ No
5. Do you have problems with grooming, bathing, dressing, eating or using the bathroom? ☐ Yes ☐ No
6. Do you require a special diet? ☐ Yes ☐ No
   - If yes, then what is the special diet? _____
7. Have you been hospitalized in the last six months? ☐ Yes ☐ No
   - If yes, provide date and reason for hospitalization: _____

Vision

8. Do you wear glasses? ☐ Yes ☐ No
   - If yes, how old are they? _____
   - If yes, do you have trouble seeing close up or far away? _____
9. When was the last time your eyes were examined? _____

Hearing

10. Do you have trouble hearing? ☐ Yes ☐ No
    - If yes, have you ever had a hearing test? ☐ Yes ☐ No
    - If yes, when? _____

Mobility

11. Do you have difficulty walking? ☐ Yes ☐ No
    - If yes, then do you use any mobility equipment? ☐ Yes ☐ No
12. Do you have problems sitting or standing for long periods? ☐ Yes ☐ No

Learning Styles and Literacy

13. Do you have difficulty following a schedule? ☐ Yes ☐ No
14. Do you have difficulty following directions? ☐ Yes ☐ No

15. Do you have difficulty reading? ☐ Yes ☐ No
16. Do you have difficulty writing? ☐ Yes ☐ No

Mental Health

17. Are you currently receiving therapy or seeing a psychiatrist? (We encourage students to continue and keep their appointments.) ☐ Yes ☐ No
18. Are you currently using or have recently used illegal substances, including marijuana? ☐ Yes ☐ No
19. Will you be able to pass drug screening when you begin your training program? ☐ Yes ☐ No

Accommodations

20. Are there any services or supports that will help you be successful in your program? ☐ Yes ☐ No

Legal

21. Is there anything in your legal history that will affect employment? ☐ Yes ☐ No
22. Do you have any upcoming court dates? ☐ Yes ☐ No
23. Are you on parole or probation? ☐ Yes ☐ No

Employment

24. Do you want to work part-time or full-time? (check all that apply) ☐ Part-time ☐ Full-time
25. Desired employment hours (check all that apply): ☐ Day ☐ Evening ☐ Overnight

Identification

26. Do you have a valid ID? ☐ Yes ☐ No

Additional Information:

_____

_____

_____

_____

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_____

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_____

_____

_____

Staff Signature

Staff Name: _____ **Date Completed:** _____