Texas Workforce Commission
Vocational Rehabilitation Services

Referral for Provider Services

Provider Selected		
Provider name:		

Reason for Referral			
Referral for:			**Referral date:**
Service provided:	In-person	Remote	Combination of in-person and remote

Customer Information	
Customer name:	**Case ID:**
Language preference:	**Date of birth:**
Address:	
Phone (if any):	**Email (if any):**
Alternate contact name (if any):	**Relation:**
Alternate contact phone (if any):	
Alternate contact email (if any):	
Customer's reported disabilities:	

VR Contact Information	
Counselor name:	
Counselor phone:	**Counselor email:**
Rehabilitation Assistant (RA) name:	
RA phone:	**RA email:**
VR office name:	

Attachments	
Benefits reports (BSA, BPQY)	School records
Case notes	Trial Work Plan
Individualized Plan for Employment (IPE)	VR3472
Medical and/or psychological records	Waiver Plan
Other attachment(s):	

Comments, Concerns, and Questions

Additional comments, concerns, or questions for this referral (e.g., questions for a psychological or vocational evaluation):