State of Kansas
Department for Children and Families

IS-4308 Rev. 05-04

Assessment Referral

DCF Referring Office: _____
Address: _____
Case Manager Name: _____
Case Manager Phone: _____

Provider Name: _____
Provider Address: _____

Consumer Name: _____
Phone Number: _____
SSN: _____
Date of Birth: _____ Gender: _____
KAECSES Case #: _____
Medical ID#: _____

This person is being referred to you for more information regarding his/her ability to work or participate in work-related activities. Please bill the local SRS office at the address listed above, **Attention:** _____.

This referral is for:

____ Vocational Assessment
____ Psychological Evaluation
____ Psychological Evaluation with LD Evaluation
____ LD Evaluation
____ Medical Resolution
____ Other _____
____ Other _____

I have included records from:

____ Vocational Assessment/CDC dated _____
____ Psychological Evaluation
____ Psychological Evaluation with LD Evaluation
____ LD Information
____ Medical Providers
____ Definitive Medical Report
____ CASAS Appraisal/Diagnostic Results
____ SASSI Results
____ KAECSES/CAP 1
____ EES Initial Assessment Information
____ Other _____

REPORT: The intent of this referral is to help identify work options and specific plans to achieve those options. Include all applicable results in your response, including tools used, functional limitations and capabilities, vocational options, specific accommodations to maximize ability to work, local labor market options, transferable work skills, referral to other services, and specific recommendations. In addition, please address the following questions.

1.

2.

3.

Case Manager Signature: _____ **Date of Referral:** _____

cc: case file