Student Transition Referral To ADRC

Student Name_____**D.O.B.**_____

Teacher/Counselor_____ **Phone #/Ext.**_____

Teacher email address _____

Date_____ **Anticipated Graduation Date** _____

Please check and attach most recent supporting documentation (if available):

_____ **Medical History & Physical** _____ **DVR Referral**
_____ **Neuropsychological Evaluation** _____ **Most Recent IQ Score and date**
_____ **Most Recent IEP/Date of next IEP meeting?** _____
_____**Primary Diagnosis** _____

Is student receiving Children Long-Term Support or Family Support Services through county human services?

_____ **Yes** _____ **No (if yes, circle which one and provide the name of county social worker/case manager)**

_____

_____ **Does student need an interpreter? If so, what type?** _____

Does student have a childhood Disability Determination? _____ **Yes** _____ **No**

Does student need to apply for Adult Disability? _____ **Yes** _____ **No**

Brief description of needs/ _____

_____

Primary Contact Information (Parent or Guardian): **Has parent guardian given consent to contact ADRC? Y or N**

Name_____

Address_____

Phone (s) _____

Best Time To Contact _____

Please send this referral with documents identified above to ADRC Lead worker.

ADRC of Northwest Wisconsin
Email: adrc@co.polk.wi.us
Phone: 877-485-2372
Balsam Lake Office: 100 Polk Co. Plaza, #60 Balsam Lake, WI 54810 **Fax:** 715-485-8460
Siren Office: 7410 Co. Road K, #180 Siren, WI 54872 **Fax:** 715-349-8644

Office Use Only:
Date Received: _____ Received by:_____
Given to: _____
_____