

**Transition Referral Transmittal Form for In-School Youth**

**STUDENT DEMOGRAPHIC INFORMATION:**

**Date:** \_\_\_\_\_

**Student Name:** Mr. Ms. \_\_\_\_\_

**DOB:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Student Address:** \_\_\_\_\_  
Street City/State Zip Code

**Parent/Legal Guardian Name/Address: #1** \_\_\_\_\_

**Parent/Legal Guardian Name/Address: #2** \_\_\_\_\_

**Home Phone #:** (\_\_\_\_) \_\_\_\_\_ **Other Phone #:** (\_\_\_\_) \_\_\_\_\_

**Grade Most Recently Completed:** \_\_\_\_\_ **Expected Year of Graduation:** \_\_\_\_\_

**STUDENT DIAGNOSTIC INFO:**

**Referral must include copies of:**

Current IEP and psychological report (including subtest scores and observations)

or

Current 504 Plan and supporting documents

or

Current Physician Report with diagnosis

**AND Signed release of Information**

**CSE Classification, 504 or Medical Diagnosis:** \_\_\_\_\_

**Special Accommodations for Initial Interview:** \_\_\_\_\_

**REFERRAL SOURCE INFORMATION:**

**Name of Person Making Referral:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**School or Agency Referring:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**District BEDS CODE:** \_\_\_\_\_ **0\_0\_0\_0\_** **Email Address:** \_\_\_\_\_

**School District Student Resides In:** \_\_\_\_\_

**Name of School Contact to help arrange interview:** \_\_\_\_\_

**Location of Student during school days: Mornings: from:** \_\_\_\_\_ **until:** \_\_\_\_\_

**Afternoons: from:** \_\_\_\_\_ **until:** \_\_\_\_\_

**STUDENT PARTICIPATION:**

**I wish to apply for vocational rehabilitation services**

\_\_\_\_\_  
**Student Signature**

\_\_\_\_\_  
**Parent/Guardian Signature (If under 18 years old)**

**AUTHORIZATION FOR THE RELEASE\*\***  
**OF EDUCATIONAL RECORDS**

I, \_\_\_\_\_, authorize representatives of the \_\_\_\_\_  
School District to release and discuss the educational records of \_\_\_\_\_

To the following:

List names and addresses of relevant agencies/individuals

_____	_____
_____	_____
_____	_____

I understand that these educational records are being released to assist in the planning and provision of transition services and include student testing, evaluations, etc.

\_\_\_\_\_  
(list the nature of any other information to be released)

I further understand that, upon request, I have the right to inspect and receive a copy of any records sent in accordance with this release.

\_\_\_\_\_  
Parent/person in parental relationship to student over 18

Date \_\_\_\_\_  
Relationship to student

I request that I be sent a copy of any educational records released pursuant to this release.

\_\_\_\_\_  
Yes

\_\_\_\_\_  
No

\*\*This form does not authorize the release of a student's HIV status or any information involving a student's drug/alcohol use to the extent the school maintains a school based substances abuse programs. Separate forms will be required in such circumstances.

## VESID Referral and Supporting Documentation

Does the Student have a disability?  
 Is the disability a barrier to successful employment?  
 Will VESID services result in an employment outcome?

**VESID supports individuals whose disabilities impede vocational success.**

<i>Person completing</i>	<i>Date Completed</i>	<i>Documentation to include:</i>
		<p><b><u>Essential Documents:</u></b>            Completed/signed transmittal form            Completed /signed <b>Authorization to Release/Obtain Information</b>  <b>Current IEP and Current Psychological</b> (including subtest scores and observations), Of...  <b>Current 504 plan and supporting documentation, or...</b>  <b>Current Physician report with diagnosis</b></p>
		<p><b><u>Important Documents:</u></b>  <b>Current update of related services:</b>            _____ OT report (if applicable)            _____ PT report (if applicable)            _____ Speech and Language report (if applicable)            _____ Counseling report (if applicable)            _____ Behavioral Support report (if applicable)            _____ Vision Therapist Report (if applicable)            _____ Deaf/Hearing Impaired Therapist Report (if applicable)            _____ School Health Report (if applicable)</p>
		<p><b><u>Helpful Documents:</u></b>            Current Transcript            Current <b>State Assessment</b> results            Current <b>Guidance Plan</b></p>
		<p><b><u>If Available, Please Include These Documents:</u></b>            Current <b>Vocational Assessment</b> results  <b>Level One Assessment Report</b>            Level two (if applicable)            Level three (if applicable)            Career Assessment reports            Current and past employment/work experiences (supervisor reports and listed experiences)  <b>List of agencies</b> providing support to the student</p>

**Not all students who qualify for VESID services** are educationally disabled. The following is a list of common areas considered for VESID Services:

Low Vision, Hearing Impairments, Deafness, Orthopedic Impairments, Carpal Tunnel Syndrome, Low Back Strain, Leg and Knee Problems, Neck and Shoulder limitations, Arthritis, Muscular Dystrophy, Multiple Sclerosis, Cerebral Palsy, Mental Retardation, Allergies and Asthma, Diabetes, Severe Learning Disabilities, Alcohol and Drug use (in remission and treatment), Mental Health (in treatment), Controlled Epilepsy, Digestive System conditions, Cardiac problems, Respiratory Issues, Speech Impediments

**VESID College Contributions:** Individuals seeking this support toward employment must be referred by: April 15 for fall semester and September 15 for the spring semester.

**Student Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**District:** \_\_\_\_\_

## List of Disabilities common to VESID Services

Low Vision  
Hearing Impairments  
Deafness  
Orthopedic Impairments  
Carpal Tunnel Syndrome  
Low Back Strain  
Leg and Knee problems  
Neck and Shoulder limitations  
Arthritis  
Muscular Dystrophy  
Multiple Sclerosis  
Cerebral Palsy  
Mental Retardation  
Allergies and Asthma  
Diabetes  
Learning Disabilities (severe)  
Alcohol and Drug Use in remission  
Mental Health, including Depression  
Epilepsy controlled  
Digestive System conditions  
Cardiac problems  
Respiratory issues  
Speech Impediments  
And many others

A referral to VESID can be made, with consent, by a family member, friend, medical consultant, or by the person with the disability. Needed for the referral are name, address, phone number, social security number and date of birth.

Junior and Senior High School students should be referred by school personnel.