FLORIDA VISUALLY IMPAIRED AND BLIND SERVICES

PHONE: (904) 474-9768

EMAIL: REFERRAL@FLORIDAVBS.ORG

FLVBS DBS Client Initial Referral Form

Fill out the information below and email this form to referral@floridavbs.org

Field	Response
Client Name	
Date of Birth (DOB)	
PROGRAM (Select One): OB/ AP/ VR/ TRANSITION/ CHILDREN	
Date of Referral	
Phone Number	
Parent/Guardian (if applicable)	
Street Address	
City	

ZIP Code	
Client Type (Select One): Job Seeker/Student	
Client Currently Receiving or Has Received Training In (Include all that apply): *(Orientation & Mobility, Independent Living, Low Vision, Braille, Assistive Technology)*	
Reason for Referral (Brief Summary)	
Client's Overall Goals and Condition (Brief Summary)	
Does the Client Have a Criminal History? Yes or No	
Summary of Client's Criminal History (if applicable)	
DBS Representative Name	
DBS Representative Signature	