Washington State Department of Social & Health Services
Transforming lives

DIVISION OF VOCATIONAL REHABILITATION (DVR)

Referral Contact Sheet

(Turn this form in with each invoice.)

NAME

FROM DATE: TO DATE:

Date	Name of Student (include last name)	Location / Event	DVR Counselor Contacted with Referral	Release of Information Attached
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
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				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

CDHL Contract Manager's Signature: **Date:**