3075 Adeline, Suite 220, Berkeley, CA 94703● 510-841-3224 (Voice)
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# COMPUTER ACCESS REFERRAL FORM

| Client Contact Information | | Reference Contact Information | |
|---|---|---|---|
| Name | | Referred by | Referral Date |
| Address | | Referrer Phone | Fax |
| City | Zip | Address | |
| Phone ( ) | | City | Zip |
| Computer system used: ☐ PC/Windows ☐ Mac | | Job Title | |

Please describe the difficulty the Client has using a computer, and whether or not he/she uses any assistive technology currently.

**Services Requested (Check all that apply):**

❑ Computer Access Evaluation ☐ Job Accommodation Training
❑ Computer Access Training ☐ Ergonomic Evaluations
❑ Other (please describe): _____
_____
_____

**Evaluation History**

Has this client had an ergonomic evaluation? ☐ Yes ☐ No
**If "Yes," please send us a copy of this evaluation**

Has this client received instructions from a medical professional about work limitations? ☐ Yes ☐ No
**If "Yes," please send us a copy of these instructions.**

Please use this space to provide any special instructions and any other pertinent information:

**THANK YOU FOR CONTACTING THE CENTER FOR ACCESSIBLE TECHNOLOGY**