



ROCK COUNTY DEVELOPMENTAL DISABILITIES BOARD

SERVICE REFERRAL FORM

Name of individual : _____

Address: _____

Phone: _____

Referring School/Agency (if applicable): _____

D.O.B. ___ / ___ / ___

Soc. Sec. # _____

Sex: M F (circle one)

DIAGNOSIS: Verification is Necessary To Determine Eligibility for DD Board Services

MR/CD: ___ Epilepsy: ___ Autism: ___ Cerebral Palsy: ___ Brain Injury: ___
Other _____

Comments: (Provide additional information regarding diagnosed disability): _____

Legal Guardian (if applicable): _____

Address: _____

Phone: _____

Referral Form Completed by: _____

Date of Completion: _____

Return completed form to: Rock County DD Board
C/O John Weber
PO Box 2133
Janesville, WI 53547-2133