

**VR-O**

**Entry Services**

**Orientation Provider Report Form**

|  |  |  |  |
| --- | --- | --- | --- |
| VR District Office:  | Click to enter | Provider: | Click to enter |
| Session Location: | Click to enter | Date of Session: | Click to enter |
| Time of Session Start: | Click to enter | Time of Session End: | Click to enter |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |
| **Number of Individuals Attending Session:** | Click to enter |
|  |  |  |  |  |  |  |  |  |
| **Did each attending individual complete the Participant Survey?** |
|  |[ ]  Yes |  |[ ]  No |  |  |  |
| If No, please explain: | Click to enter |
|  |  |  |  |  |  |  |  |  |
| **Referral Sources:** (Please indicate the totals for each referral source) |
| Advertising | Click to enter | Independent Living Center | Click to enter |
| Drug/Rehab Program | Click to enter | Medical Clinic  | Click to enter |
| Family/Friends | Click to enter | Probation/Parole | Click to enter |
| High School/Post-Secondary Education | Click to enter | Rehabilitation Agency | Click to enter |
|  |  | Other: | Click to enter |
|  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **Comments:** | Click to enter |
|  |  |  |  |  |  |  |  |  |

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| --- |
| **Completed By:**  |
|  |  | Click to enter |
| Qualified Staff Signature |  | Date |  |
| Click to enter |  | Click to enter |
| Printed Name |  |  | Title |  |
| Phone Number: | Click to enter |  | Email: | Click to enter |