VR-O

Entry Services

Orientation Provider Report Form

VR District Office:	Provider:
Session Location:	Date of Session:
Time of Session Start:	Time of Session End:

Number of Individuals Attending Session:

Did each attending individual complete the Participant Survey?

☐ Yes ☐ No If No, please explain:

Referral Sources: (Please indicate the totals for each referral source)

Advertising
Drug/Rehab Program
Family/Friends
High School/Post-Secondary Education
Independent Living Center
Medical Clinic
Probation/Parole
Rehabilitation Agency
Other:

Comments:

Completed By:

Qualified Staff Signature

Date

Printed Name

Title

Phone Number:

Email:

Form Revised Date: 11/1/18