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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: <input type="checkbox"/> PC/Windows <input type="checkbox"/> 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):	
<input type="checkbox"/> Computer Access Evaluation	<input type="checkbox"/> Job Accommodation Training
<input type="checkbox"/> Computer Access Training	<input type="checkbox"/> Ergonomic Evaluations
<input type="checkbox"/> Other (please describe): _____ _____ _____	

Evaluation History	
Has this client had an ergonomic evaluation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," please send us a copy of this evaluation	
Has this client received instructions from a medical professional about work limitations?	<input type="checkbox"/> Yes <input type="checkbox"/> 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