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Referral Form

REFERRAL SOURCE INFORMATION:

Name: _____

Organization: _____

Contact information (email): _____ Phone #: _____

Preferred way to communicate: _____

How did you hear about us: _____

REFERRED CLIENT INFORMATION:

Name: _____

Contact information (email): _____ Phone #: _____

Address: _____

Preferred way to communicate: _____

Sex: Male/Female Age: _____ Is seeking employment: Yes/No

Community supports currently available to client: (ie. VR, brokerage, counselor, support groups)

Thank you for the referral!

Sally Stauffer, MOTR/L
&
Rachel Renick, COTA/L
Autism Consultant

