Compeer Of Lebanon County
CompeerCORPS
"Be a friend. Change a life."

Program Referral Form

Compeer of Lebanon County
4 South Fourth Street, Unit C
Lebanon, PA 17042
(717)272-8317 office or (717)304-0634 cell
www.compeer-lebanon.org
director@compeer-lebanon.org

CLIENT REFERRAL INFORMATION: to be completed by the referring agency

*CompeerCORPS staff will contact the client directly upon receiving this referral form to gather more in depth information to assist us in matching the client in a friendship connection.

Name: _____

Address: Street: _____

Apt. #: _____ City: _____ State: _____ ZIP: _____

Telephone: ( ) _____ Cell phone: ( ) _____

E-mail: _____ Date of Birth: ____/____/____

Is Transportation Available? Yes: ____ No: ____ Own a car? Yes: ____ No: ____

Age: _____ Race: _____

Religion/Faith: _____

Branch of Service: Army: _____ Navy: _____ Air Force: _____ Marines: _____

Reserves: _____ National Guard: _____ Other: _____

Years of Military Service: _____ Military Discharge Date: ___/___/___

Married: ___ Single: ___ Divorced: ___ Separated: ___ Widow/Widower: _____

Number of children: _____ Ages of Children: _____

Does client have D&A Diagnosis? Yes: ____ No: ____

Is client currently under D&A treatment? Yes: ____ No: ____

Please continue next page

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Social Functioning/Personality: _____

_____

Positive Attributes: _____

The CompeerCORPS Program provides mental health wellness through camaraderie, trust, and support with "Vet to Vet" connections

Suggestions to guide the **CompeerCORPS** volunteer in developing a friendship: _____

_____

_____

Client Availability: Daytime: ____ Evening: ____ Week-end:_____ Anytime: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Physical Limitations / Medical Conditions: _____

Referral submitted by: _____

Title: _____ Provider/Agency: _____

Address: _____ Zip: _____

Telephone: ( ) _____ Best time to call: _____

E-mail address _____

Primary Mental Health Professional (if different from above): _____

Agency/Provider: _____

Address: _____ Zip: _____

Telephone: ( ) _____ E-mail address _____

Date of Referral: _____/_____/____

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RELEASE OF INFORMATION AUTHORIZATION

Permission is hereby freely given to Compeer of Lebanon County to obtain/release/exchange treatment information from/to/with (cross off non-applicable words):

_____
(name of agency or professional)

_____
(address)

_____
(phone)

Concerning the following person:

_____
(name and birthdate)

to be limited to information pertaining to the safety and well-being of the client, to his/her participation in the Compeer program, and/or his/her relationship with their Compeer volunteer friend.

_____ _____
Signature of client or guardian* Witness
(*indicate relationship to client)

_____ _____
Date Address

NOTE: This release is effective so long as this individual is a participant in the Compeer program; or upon the receipt of a written request of the person named above, a person with legal power of attorney, or legal guardian by Compeer of Lebanon County.

Please return this form to:

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4 South Fourth Street Unit C
Lebanon, PA 17042
Phone: (717) 272-8317 Email: director@compeer-lebanon.org