Compeer of Lebanon County
4 South Fourth Street Unit C
Lebanon, PA 17042
717-272-8317

REFERRAL BY _____ TO Compeer of Lebanon County

Agency/Therapist

Please Type or Print:

Referral Date_____ Social Security No._____ BSU#: _____

Client Name_____ Phone_____

Current Address_____ Zip_____

Currently Homeless ___Y ___N History of Homelessness___Y ___N At Risk of Becoming Homeless___Y ___N

If Inpatient; bldg., unit., ward_____ Projected D/C date_____

Age_____ Sex_____ Religion_____ Race_____ Smoker ___Y ___N

Physical Description_____

Client Contact with family: _____ Frequently _____ Occasionally _____Never

If Contact, Family Member Name(s) _____

Address_____ Phone_____

Relationship _____ If Children, ages_____

Social Functioning/ Personality _____

_____

Positive Attributes _____

Current Activities/ Programs _____

_____

Interests/ Hobbies _____

Physical Limitations/ Medical Conditions _____

_____

Diagnosis _____

Symptomatic Behaviors (What does the volunteer need to know) _____

_____

Reasons for Referral (Be Specific)

1. _____

2. _____

3. _____

Goals for Relationship (Be Specific)

1. _____

2. _____

3. _____

Is it important that the consumer have a Compeer friend of a specific age, religion, ethnic background, or sexual orientation?

Please specify: _____

Age _____ Religion _____

Ethnic background _____ Sexual Orientation _____

Client available: Daytime _____ Evenings _____ Weekends _____

Does client have use of a car? _____

Additional comments and suggestions _____

_____

Referral submitted by: _____

Title: _____

Agency: _____

Address: _____ Zip: _____

Phone: _____ Best time to call _____

Primary therapist (if different from above) _____

Agency: _____

Address: _____ Zip: _____

Phone: _____

Supervisor Signature: _____ _____
(signature) (title) *(date)*

The following must be completed for all referrals.

1. Date of Birth (mo/day/yr)
___/___/___

2 Sex: (20)
1. ___ Male
2. ___Female

3. Ethnic Origin: (*check one*) **(21)**
1. ____ White
2. ____ Black
3. ____ Hispanic
4. ____ Asian/ Pacific Islander
5. ____ Native American
6. ____ Other
7. ____ Unknown

4.Marital Status: (22)
1. ____ Never married
2. ____ Married
3. ____ Widowed
4. ____ Separated
5. ____ Divorced/ Annulled
6. ____ Unknown

5. Education: (*check last grade completed*) **(23)**
00 ____None
01 ____ 1st grade
02 ____ 2nd grade
03 ____ 3rd grade
04 ____ 4th grade
05 ____ 5th grade
06 ____ 6th grade
07 ____ 7th grade
08 ____ 8th grade
09 ____ 9th grade
10 ____ 10th grade
11 ____ 11th grade
12 ____ 12th grade
13 ____ Voc/Tech/Bus Schl
14 ____ 1st year college
15 ____ 2nd year college
16 ____ 3rd year college
17 ____ 4th year college
18 ____ Graduate School
19 ____ Ungraded
99 ____ Unknown

6. Type of Residence and composition: *(check one)* **(24)**
01 ____ Own Residence
02 ____ Rental Home or Apartment
03 ____ Home of Relative or Friend
04 ____ Rooming House, Hotel, SRO
05 ____ Nursing/ Health-Related Facility
06 ____ Institution
07 ____ Community Residence
08 ____ Adult Home (PPHA)
09 ____ Family Care
88 ____ Other
77 ____ Transient/ Homeless
10 ____ Incarcerated (prison, lock-up)
11 ____Foster Home (C & Y)
12 ____ Therapeutic Foster Home
13 ____ RTF (C & Y)
99 ____ Unknown

6b. Household Composition *(check one)*
01 ____ Alone
02 ____ With Parents
03 ____ With Siblings
04 ____ With Spouse
05 ____ With Children
99 ____ Unknown
06 ____ With Other Relatives
07 ____ With Others
08 ____ In institution
09 ____ In Residence Facility
10 ____ No Permanent

7. Employment Status: *(check one)* **(27)**
01____ Illness
02 ____ Homemaker
03 ____ Student
04 ____ Retired
05 ____ Unemployable
06 ____ Institutionalized
07 ____ N/A (e.g. child)
08____ Other Non-Labor
11____ Employed: Armed Forces
12 ____ Employed: Full Time
13 ____ Employed: Part Time
21 ____ On Lay-Off
22 ____ Looking for work
23 ____ Other (e.g. moving)

8. Severely Emotionally Disabled (Youth) ____ **Y (2)** ____ **N (0)**
Severely & Persistently Mentally Ill Adult ____ **Y (1)** _____**N (0)**

9. Age at 1st Psychiatric hospitalization: (31)
_____ yrs old _____ none

10. Prior Mental Health Service: *(check one*) **(32)**
0 ____ No Prior Known Services
1 ____ Prior Inpatient
2 ____ Prior Outpatient
3____ Prior Day Program
4____ Inpatient & Outpatient
5 ____ Inpatient Day Program
6 ____ Outpatient Day Program
7 ____ Unknown

11. Additional Disabilities: (39)
PLEASE EXPLAIN
00 ____ No Disabilities_____
20 ____ Developmental_____
21 ____ Mental Retardation_____
31 ____ Alcohol_____
32 ____ Drugs_____
33 ____ Mixed Substance_____
41 ____ Blind_____
42 ____ Hearing Impaired_____
43 ____ Ambulation Impairment_____
88 ____ Other_____
99 ____ Unknown_____

12. Primary Language (18) (check one)
A ____ English
B ____ Spanish
C ____ Chinese
D ____ Creole
E ____ French
F ____ Greek
G ____ Italian
H ____ Japanese
I ____ Russian
J ____ Vietnamese
K ____ Sign Language
L ____ Other
Z ____ Unknown

13. Refugee Status (20)
1 ____ Yes
2 ____ No

14. Current or Prior History of Forensic Status?

_____ Current _____ Past _____
(year)

Compeer is aware of the sensitive nature of some of the questions asked on the referral form. It has been our experience that having as much information as possible about each individual, whether volunteer or client, increases our ability to match people successfully. All information is requested to ensure, to the greatest degree possible, the success of the matching process. Compeer does not discriminate on the basis of age, gender, ethnicity, religious affiliation, or sexual orientation.

I understand that the previous information given by me is confidential and I will help the client to the best of my ability in accordance with the policies of the agency. I will maintain complete confidentiality concerning all information on Compeer clients.

Signature: _____ Date: _____

Compeer® PROGRAM
of Lebanon County

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: **Compeer of Lebanon County**
4 South Fourth Street Unit C
Lebanon, PA 17042
Phone 272-8317 E-mail: director@compeer-lebanon.org

3/1/2000