



A SERVICE OF COMPEER OF LEBANON COUNTY

4 South 4th Street, Unit C

Lebanon Pa, 17042

717-272-8317

www.compeer-lebanon.org

director@compeer-lebanon.org

Program Referral Form

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

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: ____/____/____ Signature _____

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*
(*indicate relationship to client)

Witness

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 4th Street, Unit C
Lebanon, PA 17042**