



4 South 4th Street, Unit C
Lebanon Pa, 17042
717-272-8317

www.compeer-lebanon.org
director@compeer-lebanon.org

REFERRAL BY _____ TO Compeer of Lebanon County

Agency/Therapist

Please Type or Print:

Referral Date _____ Social Security No. _____

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 _____

Interests/ Hobbies _____

Physical Limitations/ Medical Conditions _____

Diagnosis: _____

Symptomatic Behaviors: _____

Reasons for Referral (Be Specific)

1. _____

2. _____

3. _____

Current Activities/Programs

- Halcyon
- Support Groups
- Peer Support

_____ (Agency)

MHID: _____

_____ (Name of Case Manager)

Other: _____

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

**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 _____

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
10 Incarcerated (prison, lock-up)
11 Foster Home (C & Y)
12 Therapeutic Foster Home
13 RTF (C & Y)
88 Other
77 Transient/ Homeless
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)

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: _____



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):

_____ **MH/ID** _____

_____ **220 E. Lehman St. Lebanon, PA 17046** _____
(address)

_____ **717-274-3415** _____
(phone)

Concerning the following person:

_____ (name and birth date)

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**



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 referring agency or professional)

(address)

(phone)

Concerning the following person:

(name and birth date)

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**