# Program Referral Form
## Compeer Friendship Program

Mental Health Association in Butler County
140 N. Elm Street, Suite A, Butler, PA 16001
Phone: (724) 287-1965
Email: compeer@sphs.org
Fax: (724) 287-7090

**CLIENT REFERRAL INFORMATION:** to be completed by the referring Agency

Date of Referral: _____/_____/____

Name: ____________________________________________________________

Address of Residence: Street: ___________________________________________

Apt. #: ______ City: __________________________ State: _____ ZIP: ___________

Mailing Address: Street: ________________________________ P.O. Box: ________

City: __________________________ State: _____ ZIP: ___________

Telephone: ( ) __________________ Email: _________________________________

Date of Birth: ____/____/____ Age: ______

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

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

Number of children: ________ Ages of Children: _____________________________

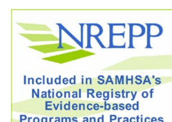
Contact with Family: ___ Yes ___ No Family or Friend ___________________________

Contact Information/Telephone: ______________________________________________

____ Spouse ____ Parent ____ Child ____ Other _________________________________

Source of Income, if known: (e.g., SSI, Social Security, Veteran, Rentals, Pension, Wages)

Educational Background: ____________________________________________________



Employment History: ____________________________________________

Current Hobbies or Special Interests: ________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

(Please provide information that will assist in making a friendship connection with a Compeer volunteer.)

Social Functioning/Personality: ____________________________________

Positive Attributes: _________________________________________

Suggestions to guide the Compeer volunteer in developing a friendship: __________

____________________________________________________________

Preference to: Age: ____ Smoker: Yes: ____ No: ____

Client Availability: Daytime: ____ Evening: ____ Weekend: _____ Anytime: _______

**<u>PSYCHIATRIC</u>: Background Information**

Primary Diagnosis: ___________________________________________

Secondary Diagnosis: __________________________________________

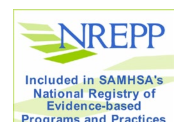
Physical Limitations/Medical Conditions: ______________________________

Symptomatic Behaviors: _______________________________________

Does the client have dual diagnosis? …MH/ID…MH/D&A (circle one) _____ Yes ____ No

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

Has the client ever been convicted of a felony or a criminal act? _____ Yes ____ No



Please give a brief description of the client's stability, cooperativeness, and desire to participate in the Compeer Friendship Program: ________________________________

________________________________________________________________________

Has this client been: Hospitalized? _____ Yes ____ No

Residential Care? _____ Yes ____ No

Transitional rehabilitation? _____ Yes ____ No

Has the client been hospitalized for mental health treatment? Discharge Date: _______

Location and Reason Why: __________________________________________________

Please rate the "Priority of Need" for support through friendship: 1 = highest 10 = lowest

1 2 3 4 5 6 7 8 9 10 (circle one) Reason: ________________________________

**REFERRAL submitted by**: _______________________________________________

Title: ______________________ Provider/Agency: _____________________________

Address: _________________________________________________ Zip: __________

Telephone: ( ) ____________________ Best time to call: _______________________

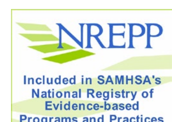
Primary Therapist (if different from above): ___________________________________

Agency/Provider: ________________________________________________________

Address: _________________________________________________ Zip: __________

Telephone: ( ) ____________________ Email: ________________________________

**It is understood by the Referring Provider Agency** that the applicant will be placed on ***a list of referred clients waiting for a friendship connection***, at times volunteers from the community may not be immediately available. All information on this referral form is held confidential with HIPAA compliance.



**RELEASE OF INFORMATION** **COMPEER FRIENDSHIP PROGRAM**

Mental Health Association in Butler County
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Butler, Pennsylvania 16001

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I, ____________________________________, do hereby consent to and authorize __________________________________________ to disclose information to the

________ Compeer Program Staff/Volunteer
________ Mental Health Advocate or Referring Agency
________ Other: ______________________________________________

Information from my case records. I understand the reason for this *Release of Information* is to facilitate program guidelines, and to allow program coordinators and advocates to discuss information with collaborative agencies, providers, or others for the purpose of helping with a specific problem or complex situation.

I understand that information discussed in consultation and networking with services could include:

Social Services _____ Therapy Notes _____ Peer Services _____ Compeer _____
Substance Abuse (Drug/Alcohol) _____ Hospitalizations _____ Case Management____
Other (please explain): ___________________________________________________

*This statement must be signed upon entering the Compeer Program at the Mental Health Association and may be revoked at any time. This Release of Information will remain confidential and in compliance with the Mental Health Association's HIPAA policy guidelines. This Release of Information will remain in force for a reasonable period of time and may be updated periodically.*

Signed: ________________________________________

Witness: ________________________________________

Date: ________________________________________