CompeerCORPS
Camaraderie • Support • Friendship

Program Referral Form
"Vet2Vet" Connection

Compeer of Suburban Philadelphia
411 Dartmouth Ave. Swarthmore, PA 19081
(610) 541-0790 or 1-800-564-PEER
Fax: (610) 541-0792
www.compeerfriends.org

CLIENT REFERRAL INFORMATION: to be completed by the referring Agency

Name: _____

Address of Residence: Street: _____

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

Mailing Address: Street: _____ P.O. Box: _____

City: _____ State: _____ ZIP: _____

Telephone: ( ) _____ E-mail: _____

Date of Birth: ____/____/____

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

Age: _____ Height: _____ Weight: _____ 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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(Please give information that will help in making a good friendship connection with a volunteer.)

Current Hobbies or Special Interests: _____

_____

_____

Social Functioning/Personality: _____

Positive Attributes: _____

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

Stability & willingness to participate in the **CompeerCORPS** Program:_____

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

_____

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

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: _____

Primary Therapist (if different from above): _____

Agency/Provider: _____

Address: _____ Zip: _____

Telephone: ( ) _____

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It is understood by the Referring Provider Agency that the applicant will be placed on a waiting list because volunteers from the community may not be immediately available to complete a "vet to vet" connection. All information on this referral form is held confidential with HIPAA compliance.

Date of Referral: _____/_____/____

RELEASE OF INFORMATION: CompeerCORPS Program

Compeer of Suburban Philadelphia
411 Dartmouth Ave.
Swarthmore, PA 19081

Phone: (610) 541-0790
Fax: (610) 541-0792

I, _____, do hereby consent to and
Authorize _____ to disclose to the

_____ CompeerCORPS Program Director / Volunteer
_____ Mental Health Advocate
_____ Voice and Vision
_____ 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.

This statement must be signed upon entering the CompeerCORPS Program or programs at the Voice and Vision Inc. and may be revoked at any time. This Release of Information will remain confidential and in compliance with the Compeer of Suburban Philadelphia 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: _____