Making Friends Changing Lives
Compeer® Lancaster

Referral Form

For one-to-one Friendship Program

Please complete both sides and return with a signed Compeer release form.
****Clients referred must have been under your care for minimum of six months****

NOTE: Referral and Release are effective for 1 year after signed by client.
After a year, referral will need to be renewed.

Referral Date _____ Birth date _____

Client Name _____ Primary number _____

Secondary phone number_____ Email address _____

Address _____

City _____ Zip Code _____

Gender _____ Race _____ Religion _____Smoker? Yes ( ) No ( )

Household Composition: Alone _____ Spouse _____ Children _____ Parents_____ Others _____

Residence: Own ____ Rental home/Apt ____

_____

Group Home _____ CRR ____ SLP _____ Diversion home _____ Other_ _____

Military Service: (Branch and dates of service): _____

Employment Status: Unemployed _____ Part Time _____ Full Time _____ Retired _____

Searching for Job _____

Client contact with family: Frequently _____ Occasionally _____ Never _____

If contact, family member name(s) _____ Relationship _____

Primary phone _____

Secondary phone _____

Emergency contact if other than family: Name _____

Day phone _____ Relationship _____

Social functioning/personality _____

Positive attributes _____

_____

Current activities/programs _____

Interests, hobbies, skills _____

_____

Is client prompt and reliable in keeping appointments and returning phone calls? Yes ( ) No ( )

If no, explain: _____

_____

_____

245 Butler Avenue, Suite 204, Lancaster, PA 17601 Phone: 717-397-7461 Fax: 717-517-8446

Email: jmills@compeerlancaster.org Website: www.compeerlancaster.org

Physical limitations/medical conditions/dietary restrictions: None _____

Developmental ____ Intellectual Disability ____ Blind ____Hearing Impaired ____Ambulation Impaired

____Obesity ____Other___ Physical Description: _____

Does this client have a primary diagnosis of mental illness? Yes ( ) No ( )

Symptomatic behaviors due to mental illness (what the volunteer needs to know): _____

_____

_____

Current medications _____

_____

Does client have a history of frequent hospitalizations? Yes ( ) No ( ) Dates of psychiatric hospitalizations in past two years:_____

Describe client's ability to tolerate frustration _____

Describe client's ability to adhere to limits _____

Has client ever been convicted of a felony or criminal activity? Yes ( ) No ( )

Does client have a history of physically aggressive behavior? Yes ( ) No ( )

If yes to either question, please describe _____

_____

Have you ever made a visit to the client's home? Yes ( ) No ( ) If yes, did you have any safety concerns? (i.e. aggressive dog, hostile family member, unsafe neighborhood) _____

Reasons for referral (Be specific) _____

_____

Goals for relationship (Be specific) _____

_____

The Compeer policy is to match volunteer and friend of the same gender. Does the client have a preference regarding age, religion or ethnic background? Please specify _____

_____

Best time to contact client: Daytime_____ Evening _____ Weekends _____

Transportation: Drivers License? _____ Own Car? _____ Access to Car? _____

Bus? _____ Walk? _____ Other? _____

If a Compeer Calling Volunteer is available, would client like to have a weekly call just to chat while s/he is waiting for a Compeer friend? Yes ____ No ____

Referral submitted by: _____

Title and agency: _____

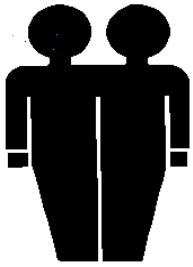
Address: _____

Phone number: _____ Email address:_____

Primary mental health professional if different than above: _____

Phone number: _____ Email address:_____

(Revised: 10/2019)



Compeer® Lancaster

REFERRAL PROCEDURES AND RESPONSIBILITIES FOR MENTAL HEALTH PROFESSIONALS

245 Butler Avenue, Suite 204 Lancaster, PA 17601
Phone: (717) 397-7461 Fax: (717) 517-8446
Email: compeer@compeerlancaster.org

MISSION STATEMENT OF COMPEER LANCASTER:

To improve the quality of life for people recovering from mental illness through the power and gift of friendship.

REFERRAL GUIDELINES:

Clients must be referred by a qualified mental health professional who is engaged in an ongoing clinical relationship with the client. A mental health professional must be trained or licensed in social work, psychology, case management or be a medical doctor. The mental health professional must know the client, see him/her for treatment on a regular basis and be willing to be consulted for intervention and consultation as situations or crisis occurs.

Clients must have a primary diagnosis of mental illness and have been under your care for a minimum of six months. The clients must be in a stage of their recovery ready for a referral to the Compeer program. Appropriate clients are:

- Able to benefit from the kind of social interaction a volunteer friend provides;
- Willing and desiring to be matched with a volunteer friend;
- Willing to participate in a volunteer program;
- Dependable in keeping appointments and returning phone calls;
- Residing at a permanent address, not currently homeless, at risk of becoming homeless, in prison or hospitalized;
- Have a rudimentary insight into their illness and are aware of the importance of maintaining a professional therapeutic alliance with the referring mental health professional throughout the duration of the Compeer match.
- **Note:** Referrals of clients with any history of criminal activity (felony), physically or sexually aggressive behavior, fire-starting, and/or a diagnosis of narcissistic or anti-social personality disorder and/or dementia should first be discussed with a Compeer staff member to determine appropriateness.

REFERRAL PROCEDURES:

- Discuss the Compeer program with your client and have the Release form signed.
- Complete both sides of the Referral form and return it with the Release to Compeer.
    - All pertinent psychiatric and medical information should be disclosed. Record symptomatic behaviors without recording a specific diagnosis.
    - List all hobbies and special interests. **A client's chance of being matched is enhanced by positively reflecting the referred individual's personality and interests.** All requested information is important to facilitate a complementary match with a volunteer.
    - Additional comments, concerns and information are welcome and helpful.

MATCHING PROCEDURES:

1. Volunteer is interviewed, screened, and trained by Compeer staff.

2. Volunteer chooses a potential friend from a list of profiles selected by the Compeer Coordinator based on age, smoking preference, geographic location, mutual interests and hobbies, level of client functioning as well as skill level and experience of the volunteer.

3. **Volunteer calls the referring mental health professional for the purpose of gaining additional information about a potential friend.** Volunteer will choose from a list of questions in the Compeer Training Manual as well as any other questions s/he wishes to know. To avoid disappointment, it is best not to inform the client about the potential volunteer until the Compeer Volunteer Coordinator calls to confirm the match.

4. A match meeting is arranged in a public place with the mental health professional, client, volunteer, and Compeer Coordinator and the friendship begins.

5. The mental health professional, Compeer Coordinator and volunteer will maintain a mutually supportive relationship throughout the friendship. Compeer staff will contact the mental health professional to report serious concerns or problems that cannot be resolved. The mental health professional will be the point of contact with Compeer staff should a crisis situation occur.

6. The mental health professional is asked to monitor the Compeer relationship and report any concerns to the Compeer office.
    a. Concerns about inappropriate behavior or activities should be reported immediately to the Compeer office.
    b. If your client leaves the treatment against medical advice, please notify the Compeer office immediately.
    c. Any pertinent information such as change in the referred individual's status, change in address, change in case manager, etc. should be reported to the Compeer officer as soon as possible.
    d. **Special Note**: Please notify the Compeer office as soon as possible if your client is hospitalized, so that the volunteer may call, send a card or visit his/her friend at the appropriate time.

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RELEASE OF INFORMATION FORM

245 Butler Avenue, Suite 204, Lancaster, PA 17601
Phone: (717) 397-7461
Fax: (717) 517-8446
Email: compeer@compeerlancaster.org

NOTE: This release is valid from date of signature and is effective so long as this individual is a participant in the Compeer Program and continues a clinical relationship with the mental health professional or agency listed below. It may be revoked or withdrawn by the client at any time.

Client: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Referring Mental Health Professional:

Name**:** _____

Title: _____

Agency: _____

Phone Number & Email: _____

I hereby authorize _____ to release
Referring Mental Health Professional/Agency
information about me to the Compeer Lancaster program. The information may include medications, hospital admissions, social history and psychiatric symptoms. I understand that this information will be used to match me with an appropriate Compeer volunteer friend and to maintain my safety and well-being throughout the duration of my Compeer friendship match.

I have read this form carefully and understand what it means.

_____ _____
Signature of client Date

_____ _____
Signature of referring mental health professional Date

Mental Health America of Lancaster County

A program of Mental Health America of Lancaster County