Client Referral Form

Date _____ County of Residence: _____

Person Making Referral (Name, Relation, Phone #) _____

Client's Name _____ SSN xxx-xx-_____ Date of Birth _____

Address _____ City/Zip _____ Phone _____

Gender: Male □ Female □ Marital Status: _____ Ethnicity: _____

Emergency Contact: (Name, Relation, Phone #) _____

In need of respite? (full-time caregiver needs a break) □ Yes □ No

If yes, please explain the situation _____

_____

What are the client's expectations of a SCP volunteer?

_____

Veteran: □ Yes □ No Smoker: □ Yes □ No Pets: □ Yes □ No (Breed) _____

Functional Limitations (check all that apply)

Speech _____ Vision _____ Hearing _____Walker _____ Wheelchair _____ Disabled _____ Other_____

Comments _____

_____

Does the client currently drive? □ No □ Yes
Is the client living alone? □ No □ Yes With family? □ No □ Yes
Is the client currently receiving services from any other agency? □ No □ Yes

Please return the completed Referral Form to

Panhandle Health District
Attn: Daniel Perry
Senior Companions Project Director
8500 N Atlas Rd
Hayden, ID 83835
208-415-5177 dperry@phd1.idaho.gov