FY 27- SCP Client Referral Form – ***Please Print*** – Complete All Blanks and Boxes

Date _____ County of Residence: _____

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

Print Client's Name; _____ Date of Birth_____

Print Address _____ City: _____ Zip: _____

Print Client's Phone _____

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

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

In need of respite? (full-time caregiver needs time away) □ 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 _____ Frail _____
Dementia _____ Stroke _____ Diabetes _____ Oxygen 24/7 _____ Emotional _____ Other_____

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

* Comments _____

Please return the completed Referral Form to

Panhandle Health District
Attn: Bill Steele
Senior Companions Program Director
8500 N Atlas Rd, Hayden, ID 83835
208-415-5143 (direct) bsteele@phd1.idaho.gov 208-415-5101 (fax)