mhafva

SENIOR VISITORS PROGRAM

CLIENT REFERRAL FORM

A program of Mental Health America of Fredericksburg

Date_____ Client Code_____

Client Name_____Phone_____

Preferred Name or Nickname _____

Street _____

City/Zip_____

Referred by_____ Phone_____

Agency _____

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PERSONAL DATA

DOB_____

Marital Status: S M D W Lives alone: Y N

Smoker: Y N Pets: Y N Type of Pet:_____

Grew up in_____

Past Occupation_____

Interests_____

Organizations_____

Other personal information_____

_____

Visits/Calls: AM PM EV W/E Flex Volunteer: M F Either

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MEDICAL DATA

Hearing: Ex G P Deaf Sight: Ex G P Blind

Mobility: Walks alone____ W/Assistance____ Wheelchair____

Community services: Meals/wheels Y N Paid Caregiver: Y N

Medic Alert: Y N

Are you receiving other community services:_____

MD's Name_____ Phone_____

Is someone checking on this person daily for safety?: Y N who:_____

Brief medical history_____

EMERGENCY CONTACTS

Please provide two contacts

Name_____

Street_____

City_____

Phone_____

Name_____

Street_____

City_____

Phone_____

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Directions to Client's Home: Please be specific._____

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Please fax to 540-372-3709 or mail to:

Senior Visitors Program
Mental Health America of Fredericksburg
618 Kenmore Avenue, Suite 2A
Fredericksburg, Virginia 22401
Attention: Laurie Black