

**COMPEER OF MONTGOMERY COUNTY, A PROGRAM OF THRESHOLD SERVICES
MENTAL HEALTH PROFESSIONAL'S REFERRAL FORM**

Home Page:
www.thresholdservices.org

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Silver Spring, MD 20902
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Compeer Office Use Only
Date received _____ by _____
Date logged _____ by _____
Date authorized _____ by _____

REFERRAL DATE:

CLIENT INFORMATION

Client Name:		Date of Birth: ____ / ____ / ____ Month Day Year	
Current Address:	City:	State:	Zip:
Phone:	E-mail address:		

LIVING SITUATION

Lives with (self, spouse, parents, foster parents, relatives, friends, group home, inpatient, etc.)

Legal Guardian Name (If applicable):	Phone:
Address (if different):	City: State: Zip:

For those not living with family:

Client contact with family: <input type="checkbox"/> Frequently <input type="checkbox"/> Occasionally <input type="checkbox"/> Never	
If contact, family member name(s):	
Relationship to client:	Phone:
Address:	City: State: Zip:

EMERGENCY CONTACT

Name:	Relationship to Client:
Phone (Day):	Address:
Phone (Evening):	City: State: Zip:

Does the client have access to transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No What type: <input type="checkbox"/> Car <input type="checkbox"/> Bus <input type="checkbox"/> Other _____ Is there special need for transportation? If yes, please explain (i.e. wheelchair access, etc.): _____ Current involvement in programs (e.g. Day treatment, work, volunteering, community recreation) – please list: _____

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Interests/Hobbies/Activities		
<input type="checkbox"/> Arts:	<input type="checkbox"/> Sports:	<input type="checkbox"/> Movies:
<input type="checkbox"/> Crafts:	<input type="checkbox"/> Outdoor Activities:	<input type="checkbox"/> Theatre:
<input type="checkbox"/> Sewing:	<input type="checkbox"/> Gardening:	<input type="checkbox"/> Games:
<input type="checkbox"/> Reading:	<input type="checkbox"/> Fitness Activities:	<input type="checkbox"/> Music:
<input type="checkbox"/> Animals:	<input type="checkbox"/> Dancing:	<input type="checkbox"/> Shopping:
<input type="checkbox"/> Dining Out:	<input type="checkbox"/> Volunteering:	<input type="checkbox"/> Church/Temple:
<input type="checkbox"/> Collecting:	<input type="checkbox"/> Cooking:	<input type="checkbox"/> Other:
Describe client's strengths and positive attributes:		
Please describe the client's interaction skills in the following settings:		
Group:	1:1:	
Structured:	Unstructured:	
Ability to adhere to limits:	Ability to tolerate frustration?	
How does client interact with those with authority: (i.e. mentors, mental health professionals?)		
How does client interact with peers?		
How does client interact with those of different ages?		
Describe general personality traits (e.g. engaging, defensive, anxious, verbal, etc.):		
<u>DSM Diagnosis</u> (Please Include Code with Diagnosis)		
Axis I:	Axis IV:	
Axis II:	Axis V:	
Axis III:	Severity of Disability Seriously and Persistently Mentally Ill __ Y(1) __ N(0)	
Symptomatic Behaviors (What does the volunteer need to know):		

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MENTAL HEALTH PROFESSIONAL'S REFERRAL FORM**

Does client have a history of physically aggressive behavior <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:
Has client ever been convicted of a felony or for any criminal activity? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: When? _____ Where? _____ What was the nature of the offense?
Does client have any other medical conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:
Does client have any physical limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:
Medication(s):
Any symptoms or side effects/interactions the volunteer should be aware of?
Does client have a history of illicit drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:

GOALS FOR COMPEER RELATIONSHIP/TREATMENT PLAN GOALS

1.
2.
3.

TYPE OF SERVICE CLIENT MAY BENEFIT FROM (CHECK ALL THAT APPLY)

Check all that apply:

- 1:1 Individual long-term match (1 year+)
- 1:1 Individual short-term match (3-9 months)
- Match with a couple or family (Family Volunteering)
- Group match
- Short-term match to learn skill. (Skillbuilding). List skills needed/wanted (e.g. cooking, banking, positive leisure activities, etc.) _____
- Supportive phone contact while on waiting list (Compeer Calling)

COMMENTS

Is it important that the volunteer be a specific age, gender, religion, ethnic background or have a specific quality? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify:
Please add any comments or information that will help Compeer in finding an appropriate match:
Client availability: <input type="checkbox"/> Daytime <input type="checkbox"/> Evenings <input type="checkbox"/> Weekdays: <input type="checkbox"/> Sat <input type="checkbox"/> Sun
Does client smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No Does it matter to client if volunteer smokes? <input type="checkbox"/> Yes <input type="checkbox"/> No

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MENTAL HEALTH PROFESSIONAL'S REFERRAL FORM**

Referring Mental Health Professional Name:		Title:	
Agency:			
Address:		City:	State: Zip:
Phone:	Fax:	Email:	
Best time to call:	Relationship/role with client:	Type of treatment (individual, family, group, group home, medication):	
Frequency of contact with client:		Primary contact for Compeer Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	

If NO, please list information for primary contact

Primary Mental Health Professional Contact:		Title:	
Agency:			
Address:		City:	State: Zip:
Phone:	Fax:	Email:	
Best time to call:	Relationship/role with client:	Type of treatment (individual, family, group, group home, medication):	
Frequency of contact with client:			

Do you have another therapist or primary counselors? Please list:

Mental Health Professional Contact:		Title:	
Agency:			
Address:		City:	State: Zip:
Phone:	Fax:	Email:	
Best time to call:	Relationship/role with client:	Type of treatment (individual, family, group, group home, medication):	
Frequency of contact with client:			

If you are referring someone who is not a client of Threshold Services:

Is your client presently receiving Entitlement? <input type="checkbox"/> Yes <input type="checkbox"/> No
Entitlement received:
Income from all sources (e.g. trusts, wages, social security, annuities, dividends, interest): \$ _____ (required)

Verification of income and entitlement must accompany this application for non-Threshold Services clients. The application cannot be processed until verification is received.

MENTAL HEALTH PROFESSIONAL'S REFERRAL FORM

The following items are for statistical purposes and to help us match your client:

1. Gender:

- 1 ___ Male
2 ___ Female

2. Social Security No.:

___ - ___ - ___

3. Ethnic Origin: (check one)

- 10 ___ White
20 ___ Black-Unspecified Origin
21 ___ African-American
22 ___ Black-of Jamaican Origin
23 ___ Black-of Other Origin
30 ___ Hispanic-Unspecified Origin
31 ___ Hispanic-of Puerto Rican Origin
32 ___ Hispanic-of Central American Origin
33 ___ Hispanic-of Other Origin
40 ___ Asian/Pacific Islander-Unspecified Origin
41 ___ Asian/Pacific Islander-of Chinese Origin
42 ___ Asian/Pacific Islander-of Indo-Chinese Origin
43 ___ Asian/Pacific Islander-of Indian/Pakistani Origin
44 ___ Asian/Pacific Islander-of Other Origin

4. Type of Residence: (check one)

- 01 ___ Own Residence
02 ___ Rental Home/Apartment
03 ___ Home of Parent, Relative, or Friend
04 ___ Rooming House, Hotel, SRO
05 ___ Nursing/Health Related Facility
06 ___ Institution
07 ___ Community Residence
08 ___ Adult Home (PPHA)
09 ___ Family Care
10 ___ Incarcerated (prison, jail, lock-up)
11 ___ Foster Home (C&Y Clients)
12 ___ Therapeutic Foster Home
13 ___ RTF (C&Y Clients)
77 ___ Transient/Homeless
88 ___ Other
99 ___ Unknown

5. County of Residence: (check one)

- 28 ___ Montgomery
26 ___ Howard
59 ___ Prince George's
___ Other MD County

(specify)

6. Marital Status:

- 1 ___ Never Married
2 ___ Married
3 ___ Widowed
4 ___ Separated
5 ___ Divorced/Annulled
9 ___ Unknown

- 50 ___ Native American
60 ___ Bi-Racial _____
90 ___ Unknown / Other

7. Education: (check last grade completed)

- 01 ___ No Education
02 ___ Less than high school
03 ___ Some high school
04 ___ High school/GED diploma
05 ___ Vocational, technical, business school
06 ___ Some college
07 ___ 2 year college degree
08 ___ 4 year college degree
09 ___ Graduate School
10 ___ Unknown

8. Household Composition: (check one or more)

- 01 ___ Alone
02 ___ With Parents
03 ___ With Siblings
04 ___ With Spouse
05 ___ With Children
06 ___ With Other Relatives
07 ___ With Others
08 ___ In Institution
09 ___ In Residence Facility
10 ___ No Permanent
99 ___ Unknown

9. Religion: (check one)

- 01 ___ Roman Catholic
02 ___ Protestant
03 ___ Baptist
04 ___ Pentacostal
05 ___ Methodist
06 ___ Jewish
07 ___ Islam
08 ___ Buddhist
09 ___ Hindu
10 ___ Christian Scientist
11 ___ Jehova's Witness
88 ___ Other
99 ___ Unknown

Congregational Affiliation: _____

(Please specify)

10. Primary Language:

- A ___ English
B ___ Spanish
C ___ Vietnamese
D ___ Sign
E ___ Braille
F ___ Other
Z ___ Unknown

11. Income Source: (check largest single source)

- 00 ___ None
01 ___ Full-time Employment
02 ___ Part-time Employment
04 ___ Alimony or Child
05 ___ Unemployment
06 ___ Pension, Social Security
07 ___ Support Employed Spouse
08 ___ Support from Employed Parent
11 ___ SSI
12 ___ SSDI
13 ___ ADC, Home Relief of other Welfare
14 ___ VA Benefits
15 ___ Workers Compensation
88 ___ Other
99 ___ Unknown

12. Patient Funding Source Eligibility:

- 01 ___ Self Pay (Only)
03 ___ Medicaid (Mont. County)
05 ___ Medicaid (Other county)
06 ___ Medicare
10 ___ MD Disability
11 ___ BC/BS
12 ___ Preferred Care
13 ___ Prospective Payment Pkgs.
14 ___ DSS
15 ___ Worker's Compensation
16 ___ Other _____
17 ___ Education
20 ___ VESID (Vocational and Educational Services for Individuals with Disabilities)
21 ___ SSI
22 ___ SSDI
23 ___ Medicaid Capitation
88 ___ Other
99 ___ Unknown

13. Additional Disabilities: . . . Please Explain

- 00 ___ No Disabilities
20 ___ Developmental: _____
21 ___ Mental Retardation: _____
31 ___ Alcohol: _____
32 ___ Drugs: _____
33 ___ Mixed Substance: _____
41 ___ Blind: _____
42 ___ Hearing Impaired: _____
43 ___ Ambulation Impairment: _____
88 ___ Other: _____
99 ___ Unknown: _____

16. Prior Mental Health Service: (check one)

- 0 ___ No Prior Known Services
1 ___ Prior Inpatient
2 ___ Prior Outpatient
3 ___ Prior Day Program
4 ___ Inpatient & Outpatient
5 ___ Inpatient Day Program
7 ___ Inpatient, Outpatient, Day Program
9 ___ Unknown

