Peninsula Family Service
Opening Doors, Changing Lives

SENIOR PEER COUNSELING REQUEST FOR SERVICE REFERRAL

Participant:__________________________ **DOB:**__________**Age** ____ **Gender: M**__**F**__ **Non Binary**__

Address:________________________________ **City**______________________ **Zip Code**__________

Telephone: hm#___________________ **cell#**________________**e-mail**_______________________
Information for initial contact: ____

Race/Ethnicity: (select all that apply)

() American Indian, Alaska Native or Indigenous () Asian () Black or African American
() Native Hawaiian or Pacific Islander () White or Caucasian

() Asian Indian/South Asian
() Cambodian
() Chinese
() Filipino
() Japanese
() Korean
() Vietnamese
() Caribbean
() Central American
() Mexican/Chicano
() Puerto Rican
() South American
() Another race/ethnicity: ______________
() Chamorro
() Fijian
() Samoan
() Tongan
() African
() Eastern European
() European
() Middle Eastern
() Decline to state

Request specific cultural community based program for Participant:

() English speaking () La Esperanza Vive (Spanish) () LGBT () Filipino () Chinese

Status: Married__ Partnered__ Single__ Separated__ Divorced__ Widowed__

Living Status: () Lives alone or Lives with:_______________ Has pets/type :________________

() House () Apt () RCFE () Assisted Living () Skilled Nursing Facility Smokes () yes () no

Primary language: (select ONE)

() English () Spanish () Mandarin () Cantonese () Tagalog () Russian () Samoan () Tongan

() Another Language:_________________ *Peer Counselor preference: ()Male ()Female ()Either*

Does Participant have a disability or learning difficulty, not including or as a result of mental health conditions? (select all that apply)

() Difficulty seeing () Dementia () Physical/mobility disability () does not have a disability
() Developmental () Chronic health condition () Learning disability () Decline to state
() Difficulty hearing or having speech understood () Another Disability: ____________________

Mobility Condition: () Walker () Wheelchair () Walks independently () Bed-bound

Previous Occupation and Interest: ____

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Emergency contact: ____

Name | Relationship | Phone# | e-mail

____

Referred by: ____

Name | Agency/Relationship | Phone# | e-mail

____

Other Agencies/persons involved: ____

Agency/person | Phone# | e-mail

____

Presenting Problems: **() Isolation () Loneliness () Depression () Anxiety () Grief**
() Mild Cognitive Decline () Other ____

Reason for Referral: ____

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Is participant able and interested in attending a Support Group? No__ Yes__ On Zoom __
Computer__ Tablet__ Needs Device___

Is participant accepting and aware of referral? Yes ___ No ___

Is participant's memory clear enough to benefit? Yes ___ No ___

Are there any firearms (gun, riffle, etc.) or other weapons in the home? Yes ____ No_____

*INFORMATION COMPLETED BY:*_________________________________ *DATE:*________________

***** Fax completed request to: Ann Blick Hamer Fax #: (650)-403-4303 *****
Mail to Ann Blick Hamer, Senior Peer Counseling, 24 Second Ave, San Mateo, CA 94401
Call 650-403-4300 x 4322 with any questions

Counselor Assigned:____________________________ **Date:**__________ **Supervision Grp:** ________________

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