PROJECT HOPE REFERRAL & SCREENING FORM

Providing Brief Counseling and Social Visits to Older Adults

Last Name:	**First Name:**	**Date:**
Gender:	**Date of Birth:**	
Phone:	**Mobile:**	
Address/City/Zip		
Emergency Contact/Relationship:	**Phone:**	
Referred by/Title	**Program/Agency:** **Phone:** **Email:**	

Primary Language (if other than English): _____

Does your client (Y=Yes N=No ?= unknown)
__ **Live Alone**? If no, list household members _____
__ Report **frequently feeling down or sad** ("being depressed")?
__ Report a **loss of interest or pleasure in doing things** (less active)?
__ Have a **history of treatment for depression** or other mental health diagnosis?

If yes please explain: _____

_____

Do you feel the client would be open to counseling? YES / NO / Unsure
Is the client/senior aware of the referral to our program(s)? YES/ NO

PRIMARYCONCERN/ISSUE:_____

_____

_____

_____

We also have socialization programs (check if interested):
__**Friendly Visitor Program** (priority are those that live alone & are isolated)
__**Well Connected/COVIA** (toll-free phone based activities)

FAX to Aging & Veterans Services (209) 558-8648 558-8698 (Phone)