



Counseling Services

Referral Form

Service Requested Peer Professional
Date _____

Please complete this form and return it to Counseling Services of LBFE

*Does this elder know she/he is being referred to LBFE Counseling Services? Yes No
If you have not discussed this referral with the client please do not submit this referral until the client has been informed and she/he has agreed to the referral being made. If you wish to be notified of the status of the referral, please submit Consent to Release Information signed by the client allowing us to talk with you throughout the process.*

Demographic Information

Name: _____ Phone: _____
Address: _____ Apt./ Unit # _____
City/State _____ Zip: _____
 House Apartment Senior Building Assisted Living Transitional Care Other _____
Lives Alone: Yes No Lives With: _____
Marital Status: Married Single Widow Separated Divorced Significant Other
Birth date: _____ Gender: _____ Race/Ethnicity: _____
Spiritual Orientation: _____ Language: _____
Education Level: _____ Socially Isolated Yes No

Referral Source Information

Name: _____ Phone: _____
Agency: _____ Title: _____

Mental Health Symptoms and History

Presenting Problem / Reason for Referral: _____

Current Medications: _____

Past Mental Health Issues: _____

Physical Health History

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Amputee | <input type="checkbox"/> Cong. Heart Failure | <input type="checkbox"/> Hard of Hearing | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Constipation | <input type="checkbox"/> Headaches | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> COPD | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Deaf | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dementia | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Balance Issues | <input type="checkbox"/> Depression | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Blind | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Edema | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> MS | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Chemical Use | <input type="checkbox"/> GI Problems | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Visually Impaired |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Oxygen | <input type="checkbox"/> Wheel Chair/Walker |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Other Physical Health Information:

Financial and Health Insurance Information

Annual Income: Up to \$13,000 \$20,491 - \$ 23,920 \$ 27,431 - \$30,860 Above \$34,320
 \$13,000 - \$20,490 \$23,921 - \$27,430 \$30,861 - \$34,320

Medicare # _____

Medicaid. If yes provide number

Parts: A B C D (circle)

Other Health Insurance Provider: _____

Insurance Number: _____

Contacts

Emergency - Name: _____

Phone: _____

Health Provider: _____

Phone: _____

Building: _____

Phone: _____

Care Manager: _____

Phone: _____

Other: _____

Phone: _____

Current Services

Conservator of Finance? Yes No

Name: _____

Phone: _____

Power of Attorney? Yes No

Thank you for completing this form.
Please fax this form to:
Counseling Services - Fax (612) 721-5848

Or mail the completed form to:
Little Brothers - Friends of the Elderly
Counseling Services- 1845 E. Lake Street
Minneapolis, MN 55407

For information on Client Eligibility visit:
<http://www.littlebrothersmn.org/>

If you would like make a referral by phone or would like a referral emailed to you please call:
Nick Zeimet at (612) 746-0738 or Louise M. Anderson at (612) 746-0720.