PROVIDENCE Health & Services
Providence Holy Cross Medical Center
Providence Saint Joseph Medical Center
Providence Tarzana Medical Center

SENIOR PEER COUNSELING
VOLUNTEERS FOR SENIORS
REFERRAL FORM

Date:______________
Name:__________________________________ DOB/Age:________________Ethnicity:_______________
Phone:____ MS:_________________________
Address:____
Physician:__________________________________ Phone:______________________
☐Medicare ☐MediCal ☐HMO_________________

Referral Source:

Name:_______________________________
Hospital/Agency:______________________
Phone:_______________________________

Health Condition:____
____

Identified Problem:____
____
____

Referral Reasons: **Comments:**

☐Depression____
☐Anxiety____
☐Loneliness____
☐Relationship problems____
☐Losses____
☐Normal Aging issues____
☐Bereavement____
☐Acute/chronic conditions____
☐Caregiver Stress ____
☐Lack of support ____
☐Barely able to manage at home ____
☐Decline in ADLs ____
☐Decline in IADLs ____
☐Transportation____
☐Shopping____
☐Friendly Visiting____
☐Other Needs____
____

☐Terminate & Filed Date:____________________
☐Reinstate Date:____________________

☐**Senior Peer Counseling: Barbara Silverberg, MA, LMFT 818-847-3845**

☐**Volunteers for Seniors: Jennifer Callejas, MSW 818-847-3873**

Fax referral to 818-847-3923