

ElderFriends Elder Referral Form

Participant Information

Name:

First

Middle

Last

Present Address:

Street

City

State

Zip

Home Telephone Number: _____ Referred By: _____

Is the referred elder currently receiving services through Aging and Disability Services? Y __ N __
If yes, who is the Aging and Disability Services Case Manager assigned to them? _____

Contacts

Case Manager or Social Worker:

Name: _____ Relationship: _____

Organization: _____ Daytime Phone: _____

Contact:

Name: _____ Relationship: _____

Evening Phone: _____ Daytime Phone: _____

Demographic Information

(Check box that applies to participant)

MARITAL STATUS

Never Married/Partnered Divorced/ Separated

Married/Partnered

Widowed

GENDER

Female Male Transgender

Other: _____

RACE

African American Asian Hawaiian/ Pacific

Islander

Native American White/ Caucasian Other: _____

ANNUAL INCOME:

Very Low Income Low Income Moderate Income

Above Moderate
Income

LANGUAGES SPOKEN

English Spanish Vietnamese

Russian Chinese Other: _____

VETERAN STATUS

Served in military Veteran in household
Arm of military _____ Period of service _____

AGE: _____

BIRTHDATE: _____

HOUSEHOLD SIZE: _____

Difficulties Experienced by Participant

Below are listed several areas of physical/ mental/ emotional difficulties experienced by some older adults. Please place an "X" next to any difficulties you feel may apply to the referred elder.

- | | | |
|---|---|--|
| <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Depression | <input type="checkbox"/> Unresponsive |
| <input type="checkbox"/> Talks a lot | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Gruff, crabby |
| <input type="checkbox"/> Does not go out | <input type="checkbox"/> Diabetic | <input type="checkbox"/> Vision loss |
| <input type="checkbox"/> Hypochondriac | <input type="checkbox"/> Alcoholism or
Substance Abuse | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Chronic illness | <input type="checkbox"/> Complains a lot | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Demanding | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Heart Disease | | |
| <input type="checkbox"/> Uses Cane | | |
| <input type="checkbox"/> Uses Walker | | |
| <input type="checkbox"/> Uses Wheelchair | | |
| <input type="checkbox"/> Uses Scooter | | |
| <input type="checkbox"/> Dementia (including Alzheimer's) | | |

* If elder has a diagnosis of dementia, please indicate if it is mild, moderate or severe

Other: _____

Special Needs

Below are mental health and cognitive issues that ElderFriends needs to be aware of before we can make the most appropriate match with a volunteer. Please place an "X" next to any difficulties you know apply to the referred elder.

- Schizophrenia
- Bipolar Disorder
- Obsessive Compulsive Disorder
- Personality Disorder
- Hoarding Disorder
- Suicidal Ideation

- Developmental Disability
- Brain Injury
- Other

What other physical/mental/emotional/cognitive issues should ElderFriends know about in order to best communicate with and support the referred elder?

Interview Questions

Please ask elder the following questions:

- 1) Do you want to have a friendly visitor twice a month?

- 2) What personality characteristics would you like your visiting friend to possess?

- 3) What interests/activities are important for you to share with them?

- 4) Would you prefer a man or a woman?
- 5) Would you prefer a smoker or non-smoker?
- 6) Are you open to having a volunteer with a child? Yes ____ No ____

To be completed by person filling out referral form

Today's Date: _____

Name: _____

Relationship to elder: _____

Phone number: _____ Email address _____

**Return completed form to: ElderFriends 800 Jefferson Street, Ste. 620, Seattle, WA 98104
or fax to: 206 224.3779**