

**SENIOR VISITORS PROGRAM**  
**CLIENT REFERRAL FORM**  
A program of Mental Health America of Fredericksburg



Date \_\_\_\_\_ Client Code \_\_\_\_\_

Client Name \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Name or Nickname \_\_\_\_\_

Street \_\_\_\_\_

City/Zip \_\_\_\_\_

Referred by \_\_\_\_\_ Phone \_\_\_\_\_

Agency \_\_\_\_\_

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**PERSONAL DATA**

DOB \_\_\_\_\_

Marital Status: S M D W Lives alone: Y N

Smoker: Y N Pets: Y N Type of Pet: \_\_\_\_\_

Grew up in \_\_\_\_\_

Occupation \_\_\_\_\_

Interests \_\_\_\_\_

Organizations \_\_\_\_\_

Other personal information \_\_\_\_\_

\_\_\_\_\_

Visits/Calls: AM PM EV W/E Flex Volunteer: M F Either

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**MEDICAL DATA**

Hearing: Ex G P Deaf Sight: Ex G P Blind

Mobility: Walks alone \_\_\_ W/Assistance \_\_\_ Wheelchair \_\_\_

Community services: Meals/wheels Y N Paid Caregiver: Y N

Medic Alert: Y N

Are you receiving other community services: \_\_\_\_\_

MD's Name \_\_\_\_\_ Phone \_\_\_\_\_

Is someone checking on this person daily for safety?: Y N who: \_\_\_\_\_

Brief medical history \_\_\_\_\_

EMERGENCY CONTACTS

Please provide two contacts

Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_

Phone \_\_\_\_\_

Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_

Phone \_\_\_\_\_

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Directions to Client's Home: Please be specific. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please fax to 540-372-3709 or mail to:

Senior Visitors Program  
Mental Health America of Fredericksburg  
2217 Princess Anne St., Suite 219-1  
Fredericksburg, Virginia 22401  
Attention: Teresa Bowers, OTR/L