Referral and Intake Form for the Peer Mentoring Project

Staff Name:

Participant Name:_____

Participant Address:_____

Phone #:_____

Email:_____

Emergency Contact Name: _____

Emergency Contact Address: _____

Contact Phone #:_____

Email:_____

Referral Source:

☐ Self	☐ Psychiatrist	_____ Name	_____ Number
☐ Consumer Group	☐ Psychologist	_____ Name	_____ Number
☐ Family/NAMI	☐ Counselor	_____ Name	_____ Number
☐ Staff	☐ Social Worker/ Case Manager	_____ Name	_____ Number

Guardianship:

- ☐ Self
- ☐ Over Person
- ☐ Over Property
- ☐ Rogers
- ☐ Trustee

Primary Reason for Seeking Services

- ☐ Employmentï getting an internship or job
- ☐ Fitnessð eating better and exercising
- ☐ Socializationð making more friends
- ☐ Negotiating the mental health system better
- ☐ Independenceð going toward self-sufficiency

Services Requested:

- ☐ Career Development Services
- ☐ Health Recovery Services
- ☐ Community Resources/Social Supports Services
- ☐ Rights/Advocacy (SSDI), SSI) Assistance

Personal Information:

Date of Birth _____

Age:_____

Gender: M F T (Circle One)