



# Little Brothers - Friends of the Elderly

## Elder Referral Form

Please complete this form in its entirety, incomplete forms will be returned, and will delay elder's enrollment in LBFE program(s).

**Program(s) Referred For (please check one):**

- Ongoing visiting program** (volunteers visit twice a month) – elder lives in own home or apartment in San Francisco; is 60 or older; and is extremely socially isolated (receives no more than one in-person visit a month excluding paid helpers).
- Holiday visiting program** (Thanksgiving and Christmas) – elder lives in own home or apartment in San Francisco; is 60 or older; and will be alone on Thanksgiving and/or Christmas, and would like to have a volunteer visit them in their home.

**Today's Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Nickname/Other name:** \_\_\_\_\_

First Last

**Phone:** \_\_\_\_\_

**Building name:** \_\_\_\_\_ **Bldg. Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Cross Street:** \_\_\_\_\_

**Directions to home/Special entry instructions:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ 19 \_\_\_\_ **Age:** \_\_\_\_\_ **Sex:**  M  F

**Language(s) spoken:** \_\_\_\_\_ Can elder understand English?  Yes  No

**Ethnicity:**  African-American  Caucasian  Chinese  Filipino  Hispanic  Japanese  
 Jewish  Korean  Native American  Pacific Islander  Russian  
 Vietnamese  Other \_\_\_\_\_

**Living Situation:**  Alone  With elderly spouse/partner (65+)  With spouse/partner (<65)  
 With other elderly family member(s)  With family member(s) (<65)  Friend/Roommate (65+)  
 Friend/Roommate (<65)  With Home Health Care worker  Other \_\_\_\_\_

**Family/friends (amount of involvement):** \_\_\_\_\_

**Interests/Hobbies/Skills:** \_\_\_\_\_

**Previous occupation(s):** \_\_\_\_\_

**If elder has pets, what kind and how many?** \_\_\_\_\_

**Is it okay for children to visit?**     Yes     No     Not Sure

**Other information relevant to elder's personality/interests:** \_\_\_\_\_

**Expectations of Little Brothers:** \_\_\_\_\_

**Health Status:**

**Does elder smoke?**  Yes     No

**Medical:**     Blind     Partially Blind     Hard of Hearing     Deaf     Memory Loss     Arthritic

Oxygen     Heart     Special Diet     Hypertension     Amputee     Incontinent     Depression

Other \_\_\_\_\_

**Diabetic?**  Yes     No

**Mobility:**     Ambulatory     Amb w/ help     Cane     Walker     Wheelchair (manual)

Wheelchair (electric)     Homebound     Bedbound     Other \_\_\_\_\_

**Does elder have a care manager from any agency? ?**  Yes     No     Not Sure

Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Agency Name: \_\_\_\_\_

**Home environment/services received:** \_\_\_\_\_

**Referral Source**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Organization \_\_\_\_\_ Phone: \_\_\_\_\_

Mailing address: \_\_\_\_\_

**Other Contact (Emergency) Person (neighbor/ family/ doctor/case manager)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone \_\_\_\_\_

Address: \_\_\_\_\_

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**Please return completed form to: Little Brothers – Friends of the Elderly,  
909 Hyde Street, Suite 628, San Francisco, CA 94109    Fax: 415-771-7985    Telephone: 415-771-7957**