

Konocti Senior Support Inc.
CLIENT REFERRAL FORM
MAIL OR FAX TO:
P.O. Box 6668
Clearlake, CA. 95422
(707) 995-1417 Fax (707) 995-1411

PART A To be completed by client and/or referring person

Client's Name:

_____ DOB: _____ Phone: _____

Address

(Mailing): _____

Address

(Residence): _____

Services Being Utilized:

Referred to: ___ Senior Peer Counseling ___ Friendly Visitors (Social Visits)

Referred

by: _____ Agency: _____

Address: _____ Phone: _____

PART B Release of Information.

I, _____ (client,) hereby consent
To communication between Konocti Senior Support, Inc. and _____
(referring source). The purpose of this disclosure is to inform the above-named program that
verbal contact with Konocti Senior Support, Inc. has been made. The extent of information to be
disclosed will be: 1) if I am participating; 2) if I discontinue the program; 3) and if I am making
progress. This consent may be revoked by me at any time.

Signature of

Client: _____ Date: _____

Signature of

Witness: _____ Date: _____

PART C *To be completed by Konocti Senior Support, Inc.*

Received by: _____ Date received: _____

Counselor's Name: _____ Date Assigned: _____

Action taken/needed: _____

Date of First Contact: _____