Dear Referring Provider,

We are pleased that Compeer of the Lehigh Valley (a program of Pinebrook Family Answers) and Big Brothers Big Sisters of the Lehigh Valley have joined together to provide youth with a mental health diagnosis with community based mentoring services.

This joint venture will match screened, trained, monitored and caring community volunteers who will mentor a youth in a one-to-one relationship for one year, meeting two-four times a month to share interests, attend events, and provide positive, consistent support.

The most important role of a volunteer is to be a mentor, not a therapist, chauffeur or entertainment director. A mentor is a caring adult who is willing to be a nonjudgmental listener to a youth in need of attention.

Attached you will find our referral packet, Criteria for Acceptance, and a list of responsibilities you must agree to as the referral source.

Please review each of these documents before submitting the referral to ensure your client is eligible and appropriate for the program. We ask that you attach a psycho-social assessment of the client if you have one.

It is difficult to predict how long it will take to find an appropriate volunteer for your client — matches are made based on several factors such as age, personality traits, interests, level of client need versus the level of experience of the volunteer, and geographical location.

We utilize community volunteers in a person-centered approach to combat the stigma and other challenges facing our youth and their families. We view our program as an adjunct to therapy and other services. It cannot operate alone, so we look forward to partnering with you to meet the goals of your client.

Referrals may be submitted to:

Email: bbbs@bbbslv.org

Mail: BBBSLV, 41 S Carlisle Street, Allentown, PA 18109

Fax: 610.433.7000

Sincerely,

Compeer of the Lehigh Valley and Big Brothers Big Sisters of the Lehigh Valley

RESPONSIBILITIES OF REFERRAL SOURCE / MENTAL HEALTH PROFESSIONAL

- As the referring Mental Health Professional, you must have contact with Compeer and BBBSLV staff to help determine the best match for youth you refer. Our Consent for Release of Information allows this initial contact and ongoing contact until Compeer services end.
- You must be available by phone to Compeer staff for issues of concern throughout the match.
- You may be asked to facilitate meetings and/or other forms of communication between youth you refer, their parents or guardians, volunteers, and/or Compeer staff before and during the match.
- You must notify Compeer of any changes in a youth's mental health (including diagnosis and hospitalizations), agency/mental health provider, school, or contact information.
- Please let us know if the child / youth you refer is discharged from your care. This applies to youth waiting for a volunteer and youth who are matched.
- We will not present a youth to potential volunteers unless he or she is receiving an appropriate level of mental health treatment. If you close out a youth while he or she is still matched, Compeer staff will determine eligibility of youth to continue in the program.
- If you make a referral but do not intend to be the primary contact for us, you must verify the primary contact person is full aware of and supportive of the referral, has a copy of this document, and can agree to the responsibilities listed above.

I have read, understand, and agree to the above responsibilities as the referring mental health professional:

_____ _____

Signature Date

Is the client between the ages of 7 and 15?	☐ Yes	☐ No
Does the client reside in Northampton or Lehigh County?	☐ Yes	☐ No
Is the client experiencing any condition putting him or her at risk for maladaptive behaviors?	☐ Yes	☐ No
Is the client interested in socializing and spending time out in the community with a volunteer?	☐ Yes	☐ No
Is client's parent or guardian aware that referral is being made and supportive of referral?	☐ Yes	☐ No
If the referral by a school-based Mental Health Professional, is there an alternative contact available during school breaks, aside from the parent or caretaker (ex: outside therapist) or is the referral source available by email?	☐ Yes	☐ No

If all above questions are answered "Yes," please proceed:

Has the client ever been convicted of a sexual or violent offense?	☐ Yes	☐ No
Is the client acutely suicidal?	☐ Yes	☐ No
Is the client diagnosed with a Substance Use Disorder?	☐ Yes	☐ No
Has the client been hospitalized in the past six months for a mental health concern?	☐ Yes	☐ No
Is the client active in other community mentoring programs?	☐ Yes	☐ No

If any of the above questions are answered "Yes," please contact us prior to making referral. If all of the above questions are answered no, please proceed with referral and be sure to answer the questions below prior to submitting referral:

Is the referral completed in its entirety?	☐ Yes	☐ No
Is all information relating to client's mental health history disclosed in the referral, including any history of behaviors that would be of concern to a volunteer's safety (ex. aggressive or violent behavior, chemical dependency, stealing, and recent hospitalizations)?	☐ Yes	☐ No
If available, is a current psychosocial assessment attached?	☐ Yes	☐ No

Information provided in the referral and supporting documents will be reviewed by Compeer and BBBSLV. A decision will then be made in the best interest of your client and our volunteers. All cases are reviewed on an individual basis. Compeer Lehigh Valley and BBBSLV do not discriminate based on race, color, religion, disability, age, sex, or sexual orientation.

Information for this section may be gathered through client / family self-report or through review of documentation provided by the family or other mental health providers.

DSM DIAGNOSIS – PROVIDE NAME AND CODE	
Primary:	Environmental Stressors:
Secondary:	
Medical Conditions:	Seriously Emotionally Disturbed? (severe functional impairment or symptoms of psychosis, and multiple risk-factors) ☐Yes ☐No

Please describe the youth's interaction skills in each of the following settings:

Group:	1:1:
Structured:	Unstructured:
Ability to adhere to limits:	Ability to tolerate frustration:
How does youth interact with those with authority (i.e. parent, physicians, mental health professionals)?	
How does youth interact with peers?	
How does youth interact with those of different ages?	

What school does the child attend?	Grade Level:	School ID#:
General Personality Traits:		
Symptomatic Behaviors:		
Does youth have a history of physically aggressive behavior? ☐Yes ☐No Please describe:		
Has youth ever been charged with or convicted of a crime? ☐Yes ☐No If yes: What was the nature of the offense(s)? Location and Month/Year		
Does youth have any other medical conditions? ☐Yes ☐No Please describe:		
Does youth have any physical limitations? ☐Yes ☐No Please describe:		
Medication(s)/side effects a volunteer should be aware of:		
Does youth or youth's parent have a history of illicit drug use? ☐Yes ☐No Please describe:		
Are either parent(s) incarcerated? ☐Yes ☐No If yes, which facility?		
Has there been a Child Protective Services case opened with this family in the last year? ☐Yes ☐No Please describe:		
Does youth participate in other programs (after-school, faith-based, vocational training/part-time job/volunteer work, recreational)? ☐Yes ☐No Please list:		
Youth availability to meet with Compeer Volunteer: ☐Daytime ☐Evenings ☐Weekdays ☐Sat ☐Sun		

Is it important that the volunteer be a specific age, gender, religion, ethnic background, or have a specific quality? ☐Yes ☐No Please describe:

GOALS FOR COMPEER RELATIONSHIP/WELLNESS

Prevention:
Emotional:
Social:
Physical Activity/Nutrition:

REFERRAL SOURCE INFORMATION:

Name:			Title:
Agency:			
Address:		City:	State: Zip:
Phone:	Fax:	Email:	
Best time to call:	Relationship/role with youth:		Type of treatment (individual, family, group, medication):
Frequency of contact with youth:			Primary contact for Compeer Program? ☐ Yes ☐No If no, complete box below

Primary Mental Health Professional Contact:			Title:	
Agency:				
Address:		City:	State:	Zip:
Phone:	Fax:	Email:		
Best time to call:	Relationship/role with youth:		Type of treatment (individual, family, group, medication):	
Frequency of contact with youth:				