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PEARLS REFERRAL FORM

****This program is not a good fit for individuals with a history of bipolar disorder and/or psychosis****

Date: _____

Referring Source: _____

Reason for Referral: _____

CLIENT INFORMATION

Name: _____ DOB: _____ Age: _____ **(Must be 60+)**

Address: _____ City, State, Zip: _____

Gender: _____ Ethnicity: _____ Primary Language: _____

Phone: _____

PHQ-9 Eligibility Screening	Not at all	Several days	More than half the days	Nearly every day
In the past 2 weeks have you had…..	**0**	**1**	**2**	**3**
1. Little interest or pleasure in doing things.				
2. Feeling down, sad, or hopeless.				
3. Trouble falling asleep, staying asleep, or sleeping too much.				
4. Feeling tired or having little energy.				
5. Poor appetite or overeating.				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.				
7. Trouble concentrating on things, such as reading the newspaper or watching television.				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.				
9. Thoughts that you would be better off dead or of hurting yourself in some way.				

Please email referral form to info@mhapbc.org or fax to 561-660-8000