OUR SPACE INC
A community that cares and grows together

CLIENT REFERRAL FOR PEER SUPPORT

Referral Date:_____ **Agency:** _____

Referred by: _____ **Phone: (___)**_____

Name of Case Manager/Care Coordinator

Current Location/Address of Member: _____

Affiliated Community Based Service: ☐ MHS ☐ WCS OARS/CR ☐ CCS ☐ Wiser Choice ☐ Housing

Name of Member being Referred: _____ **Phone**: (____) _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email Address: _____ **Availability:** _____

Gender: ☐ Male ☐ Female **Identifies As:** ☐Male ☐ Female **DOB**:_____ **Children:** _____

Ethnicity: ☐ African American ☐Caucasian ☐Hispanic ☐Native American ☐Asian Other:_____

Emergency Contact: _____ **Phone:** _____

Preference for Peer Specialist: ☐ M ☐ F ☐ Either

Diagnosis/Disability/Drug of Choice:_____

Special Accommodation Needs, if any *(i.e., physical and sensory disabilities, medical needs, language, limitations, etc)*:

_____

_____

Strengths/Interests:_____

_____

_____

Safety Concerns: _____

_____

I give Our Space permission to work with all providers affiliated with my care team. I authorize the release of my complete health record to include records relating to mental health and or substance abuse treatment.

Date of Consent (written or verbal): _____ **Signature** _____

Our Space Fax Number 414-383-9016 or email mwisniewski@ourspaceinc.org