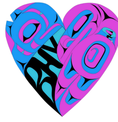
BRAVE HEART VOLUNTEERS
yee gu.aa yáx x'wán

PO Box 6336 Sitka, AK 99835 ♥ (907) 747-4600 ♥ email: kathryn@braveheartvolunteers.org

REFERRAL FOR SERVICES

MISSION - We provide companionship, respite, and education to those facing loneliness, grief, and end of life.

Referred Party/Care Receiver Information:

Name: ______________________________ Date of Birth: ______________________

Preferred phone Number: ______________________ Second phone Number:______________________

Address:____

Current Physical Location: ____

Referred By (Name/Agency):________________________ Contact Info:______________________

Services Requested: (Check all that apply)

- ☐ Companionship: we can provide 1-2 hours per week of visiting
- ☐ End of Life: we can sit bedside with someone who is dying and provide a peaceful presence
- ☐ Respite for caregivers
- ☐ Grief/bereavement support: we offer retreats, support groups, and/or a Friend in Grief (1 hour per week)
- ☐ Education: we provide education for the dying process, grief, and how to support people

Please note Brave Heart Volunteers are NOT able to provide:

- Counseling or therapy
- Anything medical (no bandaging, bathing, lifting, etc)
- House cleaning or yard work
- Driving, escorting, or errands

Reason for referral: ____
____
____

Has the Referred Party/Power of Attorney given a verbalized agreement to receive BHV services? • Yes • No

Is the Care Receiver enrolled in Home Based Services? • Yes • No

Does the referred person have a caregiver? • Yes • No

If yes, what is the Primary contact name/relationship: ______________________________
Phone number:______________________

Emergency Contact (if different than Primary): ______________________________
Phone number:______________________

Circle all that apply:

Mobility: Ambulatory Uses walker or cane Wheelchair Bed-bound

Risk for falling: • Yes • No

Cognition: ____

Grieving: • Yes • No

Challenges: Hearing Sight Other: ____

Any **additional information** that may help Brave Heart Volunteers match volunteers and coordinate services?

____

____

____

____

____

AUTHORIZATION FOR RELEASE OF INFORMATION (ROI)

Care Receiver's Name: ______________________________________ Date of Birth: ______________

RELEASE OF INFORMATION

I authorize the exchange of medical and other information both verbally and in writing which is necessary for coordination of care, including volunteer matching, and referrals for support services between Brave Heart Volunteers and the following individuals and organizations:

My family and/or caregiver(s)

SEARHC

My Physician Name______________________

Pharmacy

Sitka Pioneers' Home

Center for Community

SAIL

Other:____________________

NOTE: The signer may cross off any individual(s) or organization(s) listed above.

Care Receiver or Legal Representative **Signature:** ______________________________**Date**: ____________

Below for Completion by BHV STAFF

Meets program criteria.

☐ Visit scheduled for (date, time)________________at (location)____________________

Directions to appointment location: ______________________________________

☐ Does NOT meet BHV criteria:____