CENTRALINA Area Agency on Aging

PEARLS Program to Encourage Active, Rewarding Lives

PEARLS Referral Form

Date of Referral: ____/____/_____

Name of Client:	Enter text.
Client DOB:	Enter text.
Client Phone Number:	Enter text.
Client Email: (if applicable)	Enter text.
Client Address:	Enter text.
County:	Enter text.
Referring Staff:	Enter text.
Referring to PEARLS Staff:	Enter text.
Does the client express having depression or depressive symptoms over the course of 2 weeks or more?	Enter text.
Does the client have little interest or pleasure in doing things?	Enter text.
Does the client feel down, sad, or hopeless?	Enter text.
Is the client in an independent dwelling?	Yes/No
Client Notes:	Enter text.