Compeer is a non-profit organization serving Chautauqua County that matches volunteers with a person referred to the program by a mental health professional.

Adult Referral Packet

Please return application to:

97 Forest Avenue
Jamestown, NY 14701
(716) 487-2956
Fax (716) 484-3989

or in the North County

715 Central Avenue
Dunkirk, NY 14048
1-800-887-7337
Fax (716) 366-7840

compeer.stel.org

Sponsored by Southern Tier Environments for Living, Inc.

TY ☐ DB ☐

Compeer Chautauqua Adult Referral Form

Referral Date: _____

CLIENT INFORMATION

Client Name:	Date of Birth:	Phone:	Email:
Current Address:	City:	State:	Zip:
Physical Description:	Race:	Religion	Smoker: ☐ Yes ☐ No

Living Situation:	☐ Self ☐ Spouse ☐ Parents ☐ Relatives ☐ Friends ☐ Group Home
Client Contact with Family	☐ Frequently ☐ Occasionally ☐ Never

If contact, family name(s)	Relationship:
Address:	Phone:
If children, list names and ages:	

PSYCHOSOCIAL INFORMATION

Does the client have access to transportation? ☐ Yes ☐ No

What type? ☐ Car ☐ Bus ☐ Other _____

Are there any special needs for transportation? ☐ Yes ☐ No

If yes, please explain (i.e. wheelchair access, etc.) _____

Please list current involvement in programs (i.e. day treatment, work volunteering, community recreation):

Please check interests, hobbies and activities:

☐ Arts	☐ Crafts	☐ Sewing	☐ Reading	☐ Collecting
☐ Shopping	☐ Dining Out	☐ Gardening	☐ Outdoor activities	☐ Fitness Activities
☐ Dancing	☐ Cooking	☐ Volunteering	☐ Movies	☐ Dramas
☐ Sports	☐ Music	☐ Games	☐ Animals	☐ Church/Temple

☐ Other (list):

Describe client's strengths and positive attributes:

Describe general personality/social functioning (i.e. engaging, defensive, anxious, verbal, quiet etc.):

Does the client have any medical conditions? ☐ Yes ☐ No If yes, please describe:

Does the client have any physical limitations? ☐ Yes ☐ No If yes, please describe:

DSM IV DIAGNOSIS

Axis I (Primary):	Axis I (Secondary):
Axis II:	Axis III:
Seriously & Persistently Mentally Ill Adult ☐ Yes ☐ No	
Symptomatic Behaviors (What does the volunteer need to know?):	

COMPEER SERVICES

Please check the type of service the client may benefit from Compeer. (Check all that apply):

- ☐ 1:1 Individual Match
- ☐ Compeer Calling – supportive phone contact while on waiting list
- ☐ E-buddies – supportive email contact
- ☐ Group Events / Friends for a Day or Skill Building events while on waiting list

GOALS FOR COMPEER RELATIONSHIP/RECOVERY PLAN

1.
2.
3.

COMMENTS

Is it important that the volunteer be a specific age, religion, ethnic background or have a specific quality?

☐ Yes ☐ No Age: _____ Race _____ Religion_____ Other _____

Client availability: ☐ Daytime ☐ Evening ☐ Weekdays ☐ Weekends

Does it matter to client if volunteer smokes? ☐ Yes ☐ No

REFERRING INFORMATION

Referral Submitted By:		Title:	
Agency:			
Address:	City:	State:	Zip:
Phone:	Fax:	Email:	
Best time to call:	Relationship/Role with client:		
Frequency of contact with client:	Primary contact for Compeer Program? ☐ Yes ☐ No		

IF NO, PLEASE LIST INFORMATION FOR PRIMARY CONTACT

Name of Primary Mental Health Professional:		Title:	
Agency:			
Address:	City:	State:	Zip:
Phone:	Fax:	Email:	
Best time to call:	Relationship/Role with client:		
Frequency of contact with client:	Primary contact for Compeer Program? ☐ Yes ☐ No		

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COMPEER CHAUTAUQUA
MENTAL HEALTH PROFESSIONAL'S REFERRAL FORM
The following items are for statistical purposes and to help us match your client:

Gender:
____ Male
____ Female

County of Residence:
____ Chautauqua

Income Source: (check largest single source)
____ None
____ Full time Employment
____ Part time Employment
____ Alimony or Child Support
____ Unemployment
____ Pension, Social Security
____ Support from Employed Spouse
____ Support from Employed Parent
____ ADC, Home Relief or other Welfare
____ Medicare
____ Medicaid
____ SSI
____ SSDI
____ VA Benefits
____ Workers Compensation
____ Other
____ Unknown

Type of Residence: *(check one)*
____ Own Residence
____ Rental Home/Apartment
____ Home of Parent, Relative or Friend
____ Rooming House, Hotel, SRO
____ Nursing/Health-Related Facility
____ Institution
____ Community Residence
____ Adult Home (PPHA)
____ Family Care
____ Incarcerated (prison, jail, lock-up)
____ Foster Home (C&Y clients)
____ Therapeutic Foster Home
____ RTF (C&Y Clients)
____ Transient/Homeless
____ Other
____ Unknown

Ethnic Group:
____ White
____ African-American
____ Hispanic
____ Asian
____ Native American
____ Bi-Racial
____ Other
____ Unknown

Marital Status:
____ Never Married
____ Married
____ Widowed
____ Separated
____ Divorced/Annulled
____ Unknown

Prior Mental Health Service:
____ No Prior Known Services
____ Prior Inpatient
____ Prior Outpatient
____ Prior Day Program
____ Inpatient & Outpatient
____ Inpatient Day Program
____ Inpatient/Outpatient Day Program
____ Unknown

Education: *(check last grade completed)*
____ No Education
____ Elementary K - 6th grade
____ Junior High 7 - 9th grade
____ High School Diploma
____ GED Diploma
____ Vocational, technical, business school
____ Some college
____ 2 year college degree
____ 4 year college degree
____ Graduate school
____ Unknown

Additional Disabilities: Please explain
____ No Disabilities
____ Developmental
____ Mental Retardation
____ Alcohol
____ Drugs
____ Mixed Substance
____ Blind
____ Hearing Impaired
____ Ambulation Impairment
____ Other
____ Unknown
_____
_____
_____
_____
_____
_____
_____
_____

Religion: *(check one)*
____ Roman Catholic
____ Protestant
____ Baptist
____ Pentecostal
____ Methodist
____ Jewish
____ Islam
____ Buddhist
____ Hindu
____ Christian Scientist
____ Jehovah's Witness
____ Other
____ Unknown

Congregational Affiliation *(if known)*: _____

Primary Language: *(check one)*
____ English
____ Spanish
____ Other please specify:
____ Sign
____ Braille
____ Unknown

_____
_____
_____