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

Youth 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
(716) 366-3161
Fax (716) 366-7840

Toll Free - 1-800-887-7337

compeer.stel.org

Sponsored by Southern Tier Environments for Living, Inc.

COMPEER YOUTH REFERRAL FORM
(Please print or type)

Referral Date ______________________

Youth's Name ____ Phone ___________________

Current Street Address ____

City ______________________________________ State ___________ Zip ___________________

Date of Birth ___________ Age ______ Sex ______ Religion ____________ Race __________

Smoker? Yes ______ No ______ School ______________________________ Grade _________

Physical Description ____

Client Contact with Family: Frequently _____ Occasionally _____ Never _____

If contact, family member name(s) ____

____

Address ____ Phone _______________

Relationship ______________________________ Siblings, ages ____________________________

Social Functioning/Personality ____

____

Positive Attributes ____

Current Activities/Programs ____

____

Interests/Hobbies ____

____

Physical Limitations/Medical Conditions____

____

Symptomatic Behaviors (what does the volunteer need to know) ____________________________

____

Reasons for Referral (be specific)

1. ____

2. ____

3. ____

Goals for Relationship (be specific)

1. ____

2. ____

3. ____

Does client have a definite preference regarding age and/or race of volunteer? If so, specify below.

Age ______ Race ______ Religion ________________________

Client Available: Daytime _______ Evenings _______ Weekends _______

Does client have use of a car? ____

Additional Comments and Suggestions ____

____

Compeer Calling volunteers make a supportive, friendly telephone call each week to waiting clients. Include client in Compeer Calling? Yes ______ No ______

Referral Submitted By: ____

Title: ____

Agency: ____

Address: ____ Zip: _________

Phone: _______________________ Best time to call: _______________

Primary Therapist (if different from above:) ____

Agency: ____

Address: ____ Zip: ____________

Phone: ________________________