



The
COMMUNITY
PLACE of Greater
Rochester

*Strengthening Community, One Person,
One Family at a Time*

Senior Companion Program
Referral Form

Client Name _____
Client Address _____

Date _____
Phone _____

D.O.B. _____

	Yes	No	Comments
1. Does this person need help getting groceries?	___	___	_____
2. Does this person need help getting to medical appointments or getting prescriptions?	___	___	_____
3. Is this person socially isolated?	___	___	_____
4. Could proper nutrition be a problem due to isolation?	___	___	_____
5. Does this person's caregiver need respite?	___	___	_____

Referred by: _____ Phone: _____

E-Mail: _____ Contact for Emergency _____

Emergency contact phone: _____ Relationship to referred: _____

Physician _____ Physician phone: _____

Other Agencies involved _____

Case Worker _____ Phone _____

Home Description _____

Pets _____

OBSERVATION:

Vision _____ Walker _____ Other _____

Speech _____ Cane _____

Hearing _____ Smoker _____

Is client on a special/restricted diet? _____

Does client have any known allergies? _____

ACTIVITIES REQUESTED:

PLEASE CHECK	SPECIAL INSTRUCTIONS
<input type="checkbox"/> Socialization	
<input type="checkbox"/> Laundry	
<input type="checkbox"/> Respite	
<input type="checkbox"/> Exercise	
<input type="checkbox"/> Meals	
<input type="checkbox"/> Errands/Escort	
<input type="checkbox"/> Grocery shopping for client	
<input type="checkbox"/> Grocery shopping with client	
<input type="checkbox"/> Dr. appointment transportation	
<input type="checkbox"/> Other	

Desired schedule? (Please include number of days per week requested., number of hours per day.)

Primary language spoken by client?

Does client have specific needs regarding SC volunteer? (ex: male/female, ect.)
