CANCER RESOURCE CENTER
OF THE FINGER LAKES
612 W. State St. * Ithaca, NY 14850 * (607) 277-0960 * www.crcfl.net

PEER SUPPORT REQUEST-CAREGIVER

Date_____

Name_____

Street Address _____

City, State, Zip _____

Email_____

Home Phone_____ Cell Phone: _____

Best time to call_____ Ok to leave message? Y or N
Age: (optional-however, if you would like a peer in your age group, please include) ____

Please share your reasons for wanting to participate in the peer support program.
Please describe any significant concerns or questions you would like to speak to a peer about.

_____

_____

Information on Care Receiver's Diagnosis:

Year of Diagnosis: _____ Age: _____

Diagnosis (specific type and origin of cancer including stage)

_____

Treatments (surgery, chemo, radiation):

_____

_____

CMC Patient? Y or N (If no, treatment location? _____

I **understand that information I share with my peer mentor will be kept confidential and I agree to keep all information that my peer mentor shares with me confidential.**

Signature _____ Date_____