



Peer Support Mental Health Service

Rock Valley, IA 51247

jsears@hopehaven.org

For clients outside of Hope Haven, a verified copy of the client's diagnosis must be provided to the Hope Haven Peer Support Program

1. Referral Information

Name of person being referred: _____

Full Address: _____

City: _____ Phone Number(s): _____

Date of Birth _____ Male _____ Female

2. Desired/Recommended Mental Health Goal (Mandatory): _____

3. Funding Source:

Insurance Company or MCO _____ Policy Number: _____

Sioux Rivers Region Funding North West Iowa Care Connections Region Funding

4. Diagnosis: _____

5. Choose or list any mental health issues experienced in the last 3 or more months:

- | | |
|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety and fear |
| <input type="checkbox"/> Easily agitated | <input type="checkbox"/> Feelings of hopelessness and of being overwhelmed |
| <input type="checkbox"/> Constant worry and pessimism | <input type="checkbox"/> Isolation |
| <input type="checkbox"/> Increased use of alcohol and drugs | <input type="checkbox"/> Hearing voices, feeling others can read their minds |
| <input type="checkbox"/> Marked changes in appetite and/or sleep habits | <input type="checkbox"/> Marked changes in ability to concentrate |
| <input type="checkbox"/> Overwhelming grief | <input type="checkbox"/> Other: _____ |

Is there any risk of harm to self or others? Yes No

6. Referral source: Self Other:

If referred by person other than self, has there been a discussion with this individual about receiving this service?

Yes No

Response: _____

Name of person completing this form (please print): _____

Contact Information: _____ Date: _____