# Peer Support Mental Health Service

**Rock Valley, IA 51247**

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*A verified copy of the client's diagnosis must be provided with this form. Those already receiving services from Hope Haven will also need to ensure a copy of the verified diagnosis is in the client's file.*

**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. Substance Use Disorder:** _____

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

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

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

**7. 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:_____

**Please make sure that this referral is *fully completed* before submitting**