HOPE WELLNESS CENTER REFERRAL

The Hope Wellness Center serves adults 18 years of age and older who are in crisis, do not meet criteria for inpatient mental health services and need stabilization. They must be screened by a Physician prior to admission. This is a voluntary program that does not accept court ordered patients.

If you would like to make a referral please call the Center at 515-438-2331, complete and fax form to 515-438-2333.

The following criteria prohibit consideration of admission to HWC.

Under Arrest | *Actively Suicidal or Homicidal*

Acute Medical Needs | *High Risk of Violence*

Acutely Psychotic | *Over the Legal Limit or Impaired Due to Drug Use*

REFERRAL INFORMATION

Name: ______________________________ Birthdate ____________

Address: ____

Legal Guardian: _____ Yes _____No If yes, who: ________________________

Phone Number of Guardian: ________________

Case Manager: ____________________ Phone:________________

MCO/Insurance:____________Medicaid #:____________________

Race: _______Sex: _____ Height: _____Weight:_____ Glasses/Contacts: ______

Military: ______Religious Beliefs:______________________________

Allergies:____

Has the individual tested positive or self-reported any substance abuse in the last 24 hours? If yes, explain?

Does the individual have a history of the following?

Mental Illness _____ Yes * _____No

*Diagnosis:____

MH Provider/Agency: ____

Substance Abuse _____ Yes* _____No

*Agency/Provider:_______________________________________

Reason for Referral:

Plans for Discharge (3 to 5 days from admission):____

Current medications:

PLEASE PROVIDE RX'S FOR MEDICATION FOR AT LEAST A 3 DAY SUPPLY

Referring ER Contact and Phone: ____

Additional Comments:

I have reviewed the admission criteria and believe that the patient is appropriate for services at the Hope Wellness Center.

Referring Physician Name and Signature____

Referrals may be signed by a Psychiatrist, ARNP, PA, MD or DO

Date & Time Received by HWC: ____________________ __ Reviewed by: _________________________________

APPROVED: _________ DENIED:________