REFERRAL REQUEST FORM

☐ Adult	☐ Youth

Referring Counselor Details

First Name	Last Name	Agency

Email	Phone

Peer Details

First Name	Last Name	Date of Birth

Email	Phone

Gender

☐ Male ☐ Female ☐ Trans ☐ Non Binary ☐ Prefer not to say

Race/Ethnicity		
☐ American Indian	☐ Black/African American	☐ White/Caucasian
☐ Asian/Pacific Islander	☐ Hispanic	☐ Multiple/Other_____

Language Preference

Briefly describe the reasons for requesting a peer support specialist and specific tasks you need assistance with. In what ways could this peer benefit from Peer Support Services?

Please provide a summary of the behavioral/mental health conditions and challenges you are experiencing. Please provide any additional pertinent information you feel would be helpful in matching up you with a peer support specialist. We want the relationship to be supportive and meaningful.

Please list the number of hours per week that would be helpful to your client. Maximum 5 hours peer week

Hours				
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

For Youth Referral

Parent Name	Email	Phone

Send all referrals to: peer-support@treeofhopeassn.com