Regina Qu'Appelle HEALTH REGION

Acute Peer-to-Peer Program

Referral Date: (dd/mmm/yyyy)

Peer Assessment Form

Demographics			
Last Name:	**First Name:**		**MRN:**
Gender: ❒ F ❒ T ❒ M ❒ Other	**Date of Birth:** (dd/mmm/yyyy)	**Ethnicity:**	**PHN:**
Permanent Address: ❒ Unknown		**Phone #:**	**Language Details:**
Current Location and Contact Details: ❒ Unknown			

Referral Source Details		
Organization Name	Contact Name	Contact Number

Reason for Referral

- ❒ **New HIV+ Diagnosis**
- ❒ **Acute Care Setting**
- ❒ **Other – Specify:** _____

Presenting Issues

- ❒ **Mental Health**
- ❒ **Addicition**
- ❒ **Behavioural**
- ❒ **Health**
- ❒ **Other – Specify:** _____

Assessment Completed By: (Staff Name)	Signature:	Date: (dd/mmm/yyyy)
Final Disposition: ❒ Allocated ❒ Discharged		
Allocated to: (Key Provider) Secondary Provider)		

Regina Qu'Appelle HEALTH REGION

Acute Peer-to-Peer Program
Peer Intake Form

What are some of your interests/hobbies?

_____
_____
_____
_____

What were you doing before you were diagnosed or came to hospital? (work, school, etc.)

_____
_____
_____
_____

What do you hope to gain from having a peer mentor?

_____
_____
_____
_____

Important characteristics of peer mentor? (gender, risk factors, age, ethnicity, mental health/addiction issues, etc.)

_____
_____
_____
_____

What are the best times to have a peer mentor visit you?

_____
_____
_____
_____

What are some of the activities you would like to do with your peer mentor?

_____
_____
_____
_____