PINE REST Christian Mental Health Services

Pregnant and Postpartum
FAXED CONSENT TO CONTACT

Fax to 641.621.1493

A cover sheet is not required as it will go directly to a confidential email.
Our staff will contact the patient within one business day and fax the form to the referral source within one week of receipt.
Contact us with any concerns at 515.331.0303 (Des Moines Clinic) or 641.628.9599 (Pella Clinic).

Many pregnant moms and parents of young children feel sad, worried, anxious and overwhelmed. This fax form is used to obtain authorization for a Pine Rest Perinatal Mood and Anxiety Disorders (PMAD) HOPEline staff member to call you to discuss your emotional concerns and provide support options.

Referral Source Information:

Person Making Referral:_____ Date:___/___/___

Referral Office: _____ Contact Person: _____

Phone: (_____)_____-_____ Fax #: (_____)_____-_____

Patient Information

Patient Name: _____ Date of Birth: ___/___/___

Phone: (_____)_____-_____ Primary Insurance: _____

Edinburgh Score (If available): _____ Date:___/___/___

Patient's Authorization: I authorize my referral source to share this form with a Pine Rest PMAD HOPEline staff member, to contact me to discuss my emotional concerns and support options. I authorize Pine Rest staff to share with my referral source the type of support that I choose. (An additional release of information would be required to discuss my clinical information, if needed.)

Patient Signature: _____**Date**: ___/___/___ **Time:**_____

Pine Rest Staff to Complete Below Line

Staff completing call: _____ Date: ___/___/___ Time:_____

Outcome of call: _____

_____

_____

_____

Faxed form back to referral source Date: ___/___/___ Time: _____