

RSS Referral Form

Please send most recent hospital records, diagnostic assessment, medication list, and relevant collateral information.

Phone: 651-256-1227 Fax: 651-291-7378 Email: rssreferrals@radiashealth.org

Client Demographics

Name:

Preferred name if different from above:

DOB:

Race/Ethnicity:

Primary language spoken/written:

Gender:

Pronouns:

Sexual orientation:

Current location/Address:

Referral Source information

Name:

Agency:

Email:

Phone:

Relationship to person being referred:

Financial/Team information

Social Security Number:

MA/PMI Number:

Other Insurance:

County of Financial Responsibility:

Source of Income:

Amount:

Is person employed?: Yes/No

If yes, where?:

Team Contact Information

Mental Health Case Manager Name:

Email:

Agency:

Phone:

Emergency Contact: Name:

Email:

Emergency Contact Relationship to Person referred:

Has person had a CADI Waiver Assessment: Yes/No

If yes, CADI Case Manager: Name:

Email

Agency:

Phone

Therapist Name:

Email

Agency:

Phone:

Psychiatrist Name:

Agency:

Email:

Phone:

Guardian Name:

Email:

Agency:

Phone:

Representative Payee Name:

Email:

Agency:

Phone:

Diagnoses

Primary (please list ICD 9 codes):

Secondary (please list ICD 9 codes):

Medical Conditions:

Medical equipment used:

Can Person Ambulate Stairs with ease: Yes/No? If no please explain:

(RSS is currently not able to provide services for anyone who is permanently able to ambulate stairs or walk around the home)

Cultural Considerations

Please list/explain any cultural considerations, practices, or needs we need to be aware of for the person to best meet their needs:

Treatment and Supervision needs

Reason for referring to RSS (why is this service level needed, how do you hope it will help the person):

Is person aware of referral?: Yes/No

How does person feel about RSS placement?:

(Please ensure person is aware all common space is shared including shared bathrooms)

Does person have any pets (not including service animals). Yes / No? (RSS does not allow certain animals)

Does Person have Children that are minors? Y/N
(no minors may be in house without outside adult present)

Is person on civil commitment?: Yes/No (If yes, Please include commitment order with referral)

Jarvis?: Yes/No

Price Sheppard?: Yes/No

Is person on sex offender registry?: Yes/No

If yes, is community notification required?: Yes/No

Is person on MA restriction? If Yes, Type and explanation:

Is person in need of awake overnight? Yes/No (If no client not a fit for the RSS program)

Does person have history or current concerns with:

Non-adherence to medications: Yes / No	Recent history of dangerousness to others: Yes / No
High Vulnerability: Yes / No	Substance Use: Yes / No List substances:
Legal history/convictions Yes / No	Significant medical needs: Yes / No
Homicidal Ideation: Yes / No	Suicidal Ideation: Yes / No
Non Suicidal Self-Injury: Yes / No	Eating Disorders: Yes / No
Elopement from previous placements: Yes / No	History of Arson: Yes / No
Harm to vulnerable adults: Yes / No	Other: Yes / No _____

Please explain risk and include service needs for any answers marked yes: