RADIAS Health IRTS Referral

RADIAS HEALTH

Welcome to a full circle of care.

Please send referral form along with requested supporting documentation to our Central Access Team:

Fax: 651-677-5714 Email: centralaccess@radiashealth.org Phone: 612-453-4010

Please select the location(s) the referent would like to be considered for:

☐Community Foundations (Maplewood) ☐ReEntry House (South Minneapolis) ☐ Carlson Drake House (Bloomington, shared rooms)

What is the person's primary goal for Intensive Residential Treatment:

_____

Name of Person Referred: _____

Referral Date:_____ Date of Birth:_____

Race:

☐African American/Black **☐Asian** **☐Caucasian /White** **☐Indian (American)/Alaska** **☐Native Hawaiian/Pacific I**

☐Unknown **☐Some Other Race Alone** **☐Specify Other Race** _____

Gender and Pronouns:_____Primary Language:_____

Home Address:_____

Phone #_____ Email: _____

MA # or Insurance Type/#:_____Social Security Number:_____

MA Restriction ☐ Yes ☐No Type an Explanation:_____

Current Location: _____

County of Financial Responsibility: _____

Hospital Contact:_____

Phone #/Email:_____Anticipated D/C Date:_____

Case Manager & Agency:_____

Phone#/Email:_____

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Diagnosis

Primary Diagnosis:	
Other Diagnoses:	
Medical Conditions/Mobility Limitations:	

Treatment and Supervision Needs — Explanation

Non-adherence to medications	☐Yes ☐No	
Recent history of aggression towards property or others	☐Yes ☐No	
High Vulnerability	☐Yes ☐No	
Substance Use	☐Yes ☐No	
Legal history/convictions	☐Yes ☐No	
Significant medical needs	☐Yes ☐No	

Eligibility Checklist

IRTS admission criteria per MN DHS requirements:

☐ 18 years old or older

☐ Eligible for MHCP

☐ Diagnosed with a mental illness

☐ Has the need for mental health services that cannot be met with other available community-based services, or is likely to experience a mental health crisis or require a more restrictive setting if intensive rehabilitative mental health services are not provided as determined by the written opinion of a mental health professional

☐ Functional impairment because of mental illness, in three or more areas, utilizing the functional assessment: (check all that apply)

- ☐ mental health symptoms as presented in the adult's diagnostic assessment;
- ☐ mental health needs as presented in the adult's diagnostic assessment;
- ☐ use of drugs and alcohol;
- ☐ vocational and educational functioning;
- ☐ social functioning, including the use of leisure time;
- ☐ interpersonal functioning, including relationships with the adult's family;
- ☐ self-care and independent living capacity;
- ☐ medical and dental health;
- ☐ financial assistance needs;
- ☐ housing and transportation needs; and
- ☐ other needs and problems.

☐ One or more of the following: (check all that apply)

- ☐ History of recurring or prolonged inpatient hospitalizations in the past year
- ☐ Significant independent living instability
- ☐ Homelessness
- ☐ Frequent use of mental health and related services yielding poor outcomes

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Supporting Documentation

Please attach the following supporting documentation to assist in expediting the referral. If not all supporting documentation is available, please provide as much as possible.

Hospital Referrals:

☐ H&P (attach full physical if section refers to see separate assessment)

☐ Current medication list and MAR

☐ Recent progress notes

State Treatment Facility (e.g., CBHH/AMRTC/CARE):

☐ Need all applicable admission assessments – Psych, SW, SUD in addition to above listed hospital referral documents

Community Referrals (e.g., private residence, unhoused, crisis, jail, CD treatment):

☐ Diagnostic/Mental Health Assessment within the last year

☐ Functional Assessment within the last 6 months

☐ Documentation within the last month that can provide capture of current mental health status (e.g., ED visit, hospital notes, outpatient provider notes, etc.)

☐ Current medication list

☐ *If being referred from CD treatment (in addition to above listed documentation):

- ☐ Comprehensive Assessment
- ☐ Recent treatment plans
- ☐ Progress notes if progress is not addressed in treatment plans
- ☐ Estimated date of discharge

☐ *If being referred from jail (in addition to above listed documentation):

- ☐ Clarification of current legal standing/why they are currently in custody
- ☐ Any upcoming court hearings

☐ Case number for open cases preferred

☐ Terms of & date of release

☐ How they have been doing in jail (e.g., any behavioral incidents, interactions with mental health professionals, etc.)

Legal Status:

If applicable, please attach commitment order with referral

☐ Voluntary ☐ Commitment ☐ Jarvis ☐ Price Sheppard

Additional Information

Please provide additional context regarding how the referent meets the above criteria and can be best supported by IRTS: