RADIAS
HEALTH

IRTS Referral

Please send most recent hospital records and relevant collateral information to EACH program:

	Fax	Email	Phone
☐ Community Foundations	651-225-1545	cfreferrals@Radiashealth.org	651-221-9880
☐ ReEntry House	612-869-0313	rehreferrals@Radiashealth.org	612-869-2411
☐ Carlson Drake House	952-888-3741	cdhReferrals@Radiashealth.org	952-888-5611

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

Name of Person Referred: ____Referral Date:_________ Date of Birth:_________

Race:______________ Gender and Pronouns:____________________________ Primary Language:_________________

Address:____ Phone Number: ________________________________

MA # or Insurance Type/ #: ________________________________ Social Security Number:______________________

MA Restriction ☐ Yes ☐ No Type and Explanation:____

Current Location: _________________________________ County of Financial Responsibility: ______________________________

Hospital Contact.:____ Phone Number: ____________________________________

Case Manager: ____ Agency: ____

Phone:_________________________________ Email: ____

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Diagnoses

Primary Diagnosis:		ICD-9 Code:	
Secondary Diagnosis:		ICD-9 Code:	
Medical Conditions:			

Treatment and Supervision Needs (please complete all that apply)

		Explanation
Non-adherence to medications	☐ Yes ☐ No	
Recent history of dangerousness to others	☐ Yes ☐ No	
High Vulnerability	☐ Yes ☐ No	

Substance Use	☐ Yes ☐ No	
Legal history/convictions	☐ Yes ☐ No	
Significant medical needs	☐ Yes ☐ No	

Commitment Information: Is client currently under a commitment order? (Please include commitment order with referral) **If yes, what type:** ☐ **Commitment** ☐ **Stayed Commitment**

What is the discharge plan following treatment? What referrals are in place for this person following their IRTS placement?

_____

_____

See next page

Eligibility Checklist

□ Diagnosed with a mental illness

□ Functional impairment because of mental illness, in three or more areas, utilizing the functional assessment

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

□ 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

Please send the following documents for the most thorough assessment and treatment planning:

☐ FA
☐ DA
☐ LOCUS
☐ Hospital Records (Admission Summary, Progress Notes)

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