RADIAS HEALTH

IRTS Referral
Community Foundations, ReEntry House and Carlson Drake House

Please send the most recent hospital records and relevant collateral information to our Central Access Team:

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

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: _____

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	

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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?

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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 the above criteria and can be best supported by IRTS:

4/15/2025