Intensive Residential Treatment Services Referral Form

Brentwood Home	Fresh Start
brentwood-referrals@sfhs.org 1012 Esther Ln. Marshall, MN 56258 (507) 532-8998 ext. 201 Fax (507) 532-3049	**freshstart-referrals@sfhs.org** 1610 East First Street Duluth, MN 55812 (218) 724-2945 Fax (218) 724-0669

(Attach Current History & Physical, Psychiatric Assessment/Diagnostic Assessment, 245g Comprehensive Use Assessment, Medication List, Progress Notes, LOCUS, and Functional Assessment)

Date:	Resident Name:	DOB:	Age:
SS#:	Sex: ☐ M ☐ F		
Home Address:			
Current Location:			
Anticipated Discharge from Hospital:	Preferred Date for IRTS Admission:		
Diagnoses: Axis I: Axis II: Axis III:			
Type of Commitment: ☐MI ☐MI/CD ☐CD ☐MI&D	Guardianship/Legal Status:		
Referral Name:	Phone:	Agency:	
County Social Worker:	Phone:	County:	
Financial Worker:	Phone:	County:	
Community Therapist: Community Psychiatrist: Inpatient Psychiatric Care Provider:			
Monthly Gross Income:	Reductions to Income (amount and reason):		

Current Housing Resources

☐Bridges ☐S & C ☐Section VIII ☐CAP Apt	Applications Filed? ☐Yes ☐ No
Other Housing Resources?	Support letter for benefits applied for from physician? ☐Yes ☐ No

Health Insurance

☐MA ☐MA Pending / Date Applied:	☐Job: _____
☐Medicare ☐Minnesota Care ☐ Private Insurance	☐Social Security Pending / Date Applied:
☐CAF Completed / Date:	☐ SSI ☐SSDI / RSDI ☐GA
☐SMRT ☐SMRT Pending / Date Applied:	☐GRH ☐Waiver ☐Veteran

Sources of Income

Medical Coverage

Name of Plan:	Plan # or PMI #:
Does plan cover IRTS placement? ☐Yes ☐ No	

Goals for Placement:

☐ Recovery Goal_____

☐ Stage of Change_____

Additional Information Pertinent to IRTS Placement (support system, cultural considerations, etc.):

☐ Aggressive Behavior_____

☐ Criminal History_____

☐ Corrections Officer_____

☐ PCA Provider_____

☐ Other

Co-Occurring Medical Conditions:

☐ Allergies_____

Scheduled Appointments:

The Following Information Will Be Required Prior to Intake:

_____If referent is on a stay of commitment or full commitment, a copy of the court findings which indicate the type of commitment/Jarvis as well as a copy of the provisional discharge.

_____1-month supply of medications and original scripts for all medications.

_____Signed physician orders for all medications and insurance information faxed or called in to the appropriate pharmacy:

_____Discharge Summary

It is in the opinion of a Qualified Mental Health Professional that this individual is in need of Intensive Residential Treatment.

QMHP Signature and Credentials Date