

IRTS PLACEMENT REQUEST/REVIEW FORM

Complete the Referral Form and fax it to (612) 235-6436 with "ATTN: Intake Coordinator."

Date:	Client Name:	D.O.B.:	SSN:	Sex: M F (circle one)
Case Mgr:		Phone #:	Supervisor:	
Home Address:			Client Phone #:	
Current Location (if not home):			SW Name and #: Anticipated d/c date:	
Length of time in facility:				
Diagnoses Axis I: Axis II: Axis III:				
LOCUS Level:		Date of LOCUS:		ATTACH CURRENT LOCUS FORM
Type of Commit: <input type="checkbox"/> MI <input type="checkbox"/> MI/CD <input type="checkbox"/> CD <input type="checkbox"/> MI&D		Voluntary Client: <input type="checkbox"/> Yes <input type="checkbox"/> No		Guardianship/Legal Status:

Benefits

<input type="checkbox"/> MA open <input type="checkbox"/> MA pending PMI #:	<input type="checkbox"/> SMRT Pending <input type="checkbox"/> MN Care <input type="checkbox"/> GAMC <input type="checkbox"/> SoSec pending <input type="checkbox"/> GA
<input type="checkbox"/> SSI <input type="checkbox"/> RSDI <input type="checkbox"/> Waiv <input type="checkbox"/> Employed <input type="checkbox"/> County Pay <input type="checkbox"/> Other Source of Income:	
Applications Filed: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Commercial Insurance

Name of Plan:		
Type of Plan:		
Plan # or Consumer ID #:	Group #:	ID #:
R&B Contribution to IRTS, if any:		Client agrees? <input type="checkbox"/> Yes <input type="checkbox"/> No

Rationale for this Placement or Review (Medical Necessity, be specific)

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Goals for Placement & Treatment

1.			
2.			
3.			
4.			
Is client ambulatory? <i>If no, describe:</i>	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Does client need 24-hour nursing services?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Does client have other health care needs?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Is client insulin-dependent?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
If yes, can client administer own insulin?	<input type="checkbox"/> Y	<input type="checkbox"/> N	

Does client have poor impulse control?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Does client have history of property destruction?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Does client have history of violent behavior or threats? If yes, what specific behaviors have been observed?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Is client able to take appropriate action for self-preservation under emergency conditions (i.e. fire or severe weather conditions)? If no, describe.	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Does client have history of self-injurious behaviors? If yes, complete below:	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Describe Behavior(s), frequency, history, known triggers, and any resulting hospitalizations			
Does client have history of suicide attempts? If yes, complete below:	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Describe Attempt(s), methods, frequency, history, triggers, and any resulting hospitalizations (including dates)			
Does client have history of arson and/or is at current risk for fire setting? <i>If yes, describe.</i>	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Does client have history of sexually victimizing others and lacks behavior control? <i>If yes, describe.</i>	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Is client able to manage medical and personal hygiene needs within the scope of services provided directly or that can be brought into the facility? <i>If no, describe.</i>	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Does client take medications as prescribed? <i>If no, describe history of taking medications, medication non-compliance, "cheeking" meds, IM, etc.</i>	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Does client have history or current problems with alcohol or drugs?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Has client been through CD treatment?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
<i>If yes, describe drug of choice, sobriety/harm reduction, and other circumstances:</i>			
List treatment history:			
Is client agreeable to treatment? <i>If client is resistant, how is this presented?</i>	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Does client have past or current legal issues? <i>If yes, describe historical, current, and pending legal issues, as well as nature of offense(s) and consequences, if any:</i>	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Have there been problems in other settings?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Have there been barriers to treatment in the past? <i>If yes, describe.</i>	<input type="checkbox"/> Y	<input type="checkbox"/> N	

Additional Information pertinent to IRTS placement (support system)

Does client have support systems, cultural considerations, nutritional considerations, etc. Yes No

If yes, describe.

Post-Treatment Plans (in detail, if known):

Concerns or Risk Factors to Post-Treatment Plan:

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