

# 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                  |                          |                            |
| Case Mgr:                       | Phone #:                         | Supervisor:    |                                         |                           |                          |                            |
| Home Address:                   |                                  |                |                                         | Client Phone #:           |                          |                            |
| Current Location (if not home): |                                  |                | SW Name and #:<br>Anticipated d/c date: |                           |                          |                            |
| Length of time in facility:     |                                  |                |                                         |                           |                          |                            |
| Diagnoses                       | Axis I:<br>Axis II:<br>Axis III: |                |                                         |                           |                          |                            |
| LOCUS Level:                    |                                  | Date of LOCUS: |                                         | ATTACH CURRENT LOCUS FORM |                          |                            |
| Type of Commit:                 | MI                               | MI/CD          | CD                                      | MI&D                      | Voluntary Client? Yes No | Guardianship/Legal Status: |

### Benefits

|                     |            |       |              |            |                         |               |    |
|---------------------|------------|-------|--------------|------------|-------------------------|---------------|----|
| MA open             | MA pending | PMI # | SMRT Pending | MN Care    | GAMC                    | SoSec pending | GA |
| SSI                 | RSDI       | Waiv  | Employed     | County Pay | Other Source of Income: |               |    |
| Applications Filed: | Yes        | No    |              |            |                         |               |    |

### Commercial Insurance

|                                   |                |        |
|-----------------------------------|----------------|--------|
| Name of Plan:                     |                |        |
| Type of Plan:                     |                |        |
| Plan # or Consumer ID #           | Group #        | ID #:  |
| R&B Contribution to IRTS, if any: | Client agrees? | Yes No |

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

|  |
|--|
|  |
|--|

### Goals for Placement & Treatment

|                                            |        |
|--------------------------------------------|--------|
| 1.                                         |        |
| 2.                                         |        |
| 3.                                         |        |
| 4.                                         |        |
| Is client ambulatory?                      | Yes No |
| <i>If no, describe:</i>                    |        |
| Does client need 24-hour nursing services? | Yes No |
| Does client have other health care needs?  | Yes No |
| Is client insulin-dependent?               | Yes No |
| If yes, can client administer own insulin? | Yes No |

|                                                                                                                                                      |     |    |
|------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| Does client have poor impulse control?                                                                                                               | Yes | No |
| Does client have history of property destruction?                                                                                                    | Yes | No |
| Does client have history of violent behavior or threats?                                                                                             | Yes | No |
| <i>If yes, what specific behaviors have been observed?</i>                                                                                           |     |    |
| Is client able to take appropriate action for self-preservation under emergency conditions (i.e., fire or severe weather conditions)?                |     |    |
| Yes      No                                                                                                                                          |     |    |
| <i>If no, describe:</i>                                                                                                                              |     |    |
| Does client have history of self-injurious behaviors?                                                                                                | Yes | No |
| If yes, complete below:                                                                                                                              |     |    |
| <b>Describe behavior(s), frequency, history, known triggers, and any resulting hospitalizations</b>                                                  |     |    |
|                                                                                                                                                      |     |    |
| Does client have history of suicide attempts?                                                                                                        | Yes | No |
| If yes, complete below:                                                                                                                              |     |    |
| <b>Describe attempt(s), methods, frequency, history, triggers, and any resulting hospitalizations (including dates)</b>                              |     |    |
|                                                                                                                                                      |     |    |
| Does client have history of arson and/or is at current risk for fire setting?                                                                        | Yes | No |
| <i>If yes, describe:</i>                                                                                                                             |     |    |
|                                                                                                                                                      |     |    |
| Does client have history of sexually victimizing others and lacks behavior control?                                                                  | Yes | No |
| <i>If yes, describe:</i>                                                                                                                             |     |    |
|                                                                                                                                                      |     |    |
| 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? |     |    |
| Yes      No                                                                                                                                          |     |    |
| <i>If no, describe:</i>                                                                                                                              |     |    |
|                                                                                                                                                      |     |    |
| Does client take medications as prescribed?                                                                                                          | Yes | No |
| <i>If no, describe history of taking medications, medication non-compliance, "cheeking" meds, IM, etc.</i>                                           |     |    |
|                                                                                                                                                      |     |    |
| Does client have history or current problems with alcohol or drugs?                                                                                  | Yes | No |
| Has client been through CD treatment?                                                                                                                | Yes | No |
| <i>If yes, describe drug of choice, sobriety/harm reduction, and other circumstances:</i>                                                            |     |    |
|                                                                                                                                                      |     |    |

|                                                                                                                                  |     |    |
|----------------------------------------------------------------------------------------------------------------------------------|-----|----|
| List treatment history:                                                                                                          |     |    |
| Is client agreeable to treatment?                                                                                                | Yes | No |
| If client is resistant, how is this presented?                                                                                   |     |    |
| Does client have past or current legal issues?                                                                                   | Yes | No |
| <i>If yes, describe historical, current, and pending legal issues, as well as nature of offense(s) and consequences, if any:</i> |     |    |
| Have there been problems in other settings?                                                                                      | Yes | No |
| Have there been barriers to treatment in the past?                                                                               | Yes | No |
| <i>If yes, describe:</i>                                                                                                         |     |    |

**Additional information pertinent to IRTS placement (support system)**

|                                                                                              |     |    |
|----------------------------------------------------------------------------------------------|-----|----|
| Does client have support systems, cultural considerations, nutritional considerations, etc.? | Yes | No |
| <i>If yes, describe:</i>                                                                     |     |    |
| <b>Post-treatment plans (in detail, if known):</b>                                           |     |    |
| <b>Concerns or risk factors to post-treatment plan:</b>                                      |     |    |

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