**INTENSIVE RESIDENTIAL TREATMENT REFERRAL**

**Form should be completed by a mental health provider.**

**FAX your referral to ADMISSIONS at 612-314-1120. Include supporting documentation, such as:**

* Diagnostic Assessment
* Functional Assessment and/or LOCUS Assessment
* Medication list
* Hospital records (i.e. History & Physical) and/or record of crisis services
* Civil commitment orders, or other pertinent legal documents
* Other treatment records that support the need for IRTS placement

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| *Client Name:*  | *Preferred Name, if different from legal name:*  |
| *Date of Birth:*  | *Legal Gender*:  |
| *Client Phone:*  | *Gender Identity and/or Preferred Pronouns*:   |
| *Client Location:*  | *County of Responsibility:*  |
| *Insurance Coverage:*  | *Monthly Income Amount and Source:*  |
| *Client Diagnoses* |  |
| *Primary:*  |  |
| *Secondary:*  |  |
| *Tertiary:*  |  |
| ***Please Indicate All That Apply*** | ***Date(s) and Brief Explanation:*** |
| *Civil Commitment (MI, CD, MI/CD)* |  |
| *Legal Guardianship/Conservatorship* |  |
| *Legal Issues* |  |
| *Medication Noncompliance* |  |
| *Suicidal Behaviors* |  |
| *Self-Injurious Behaviors* |  |
| *History of Abuse, Trauma or Loss* |  |
| *History of Physical or Verbal Aggression* |  |
| *History of Sexual Aggression* |  |
| *History of Property Destruction* |  |
| *History of Fire Setting* |  |
| *Substance Use (drug and/or alcohol abuse)* |  |

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| *Mobility Considerations* |  |
| *Eating Disorder or Eating Concerns* |  |
| *Complex Physical Health Concerns* |  |
| *Person Completing this Form & Relationship to Client:*  | *Phone:*  |
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| List current and recent psychiatric hospitalizations (during the last 12 months). Include the name of each hospital and the approximate dates of (length of) admission: |
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| List current and recent community-based mental health services, crisis services, or related services the person has engaged in (during the past 12 months). Include the name of each service and the approximate dates of (length of) services: |
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| Explain why this person’s functioning indicates a need for 24-hour intensive residential services. Include any goals the person can identify, and any discharge plans following completion of IRTS: |
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| List any periods of homelessness or living instability during the past 12 months:  |
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| Is the client being referred to our Bloomington location, Minneapolis location, Fridley location, or All? If there is a preference, please explain. All residential treatment locations and grounds are tobacco-free. |
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**Referrals are reviewed and considered for admission following a determination of eligibility, and as long as documentation continues to indicate a need for IRTS level of care.** Please call the Touchstone Residential Treatment admissions line at 612-314-1100 for additional information about the program, eligibility requirements, and the referral process.