# IRTS Referral

***Please send the most recent hospital records and relevant collateral information to:***

**Info@libinprograms.org**

**Phone: 320-828-2108**

**Fax: 320-238-7682**

| | | |
|---|---|---|
| Name of Person Referred: | Date of Birth: | Referral Date: |
| Gender and Pronouns: | Race: | Primary Language: |
| Address: | | |
| Phone Number: | SSN#: | Residential Status: |
| Current Location: | Case Manager: | County of Financial Responsibility: |
| Hospital Contact: | Referral Source and Credentials: | |
| MA # or Insurance Type/ #: | | |

| | | |
|---|---|---|
| Can the client complete ADLs?* | ☐ Yes | ☐ No |
| Is the client a level 2 or 3 sex offender?* | ☐ Yes | ☐ No |
| Does the client have mobility issues?* | ☐ Yes | ☐ No |

- **Diagnoses**

| | | | |
|---|---|---|---|
| Primary Diagnosis: | | ICD-9 Code: | |
| Secondary Diagnosis: | | ICD-9 Code: | |
| ***Medical Conditions:*** | | | |

***What is the individual's primary objective for Intensive Residential Treatment?***

**Treatment and Supervision Needs (please complete all that apply)**

- ***History***

| | | |
|---|---|---|
| Non-adherence to medications | □ Yes □ No | *Specify:* |
| Recent history of dangerousness to others | □ Yes □ No | *Specify:* |
| High Vulnerability | □ Yes □ No | *Specify:* |

| | | |
|---|---|---|
| Substance Use | □ Yes □ No | *Specify:* |
| Legal history/convictions | □ Yes □ No | *Specify:* |
| Significant medical needs | □ Yes □ No | *Specify:* |

**Commitment Information: Is the client currently under a commitment order?** (*Please include commitment order with referral*) **If yes, what type: □ Commitment □ Stayed Commitment**

***What is the plan for discharge following treatment? What referrals have been arranged for this individual after their IRTS placement?***

# Eligibility Checklist

Admission is based on the assessment of a licensed mental health professional indicating that the recipient requires mental health services not available through other community-based options, or is likely to face a mental health crisis or necessitate a more restrictive setting without intensive residential rehabilitative mental health services. The professional may collaborate with a mental health case manager, county advocate, and with the consent of the recipient, their spouse, family member, or significant other. ***The recipient must:***

- ☐ - Have a diagnosed mental illness as per a diagnostic assessment.
- ☐ - Undergo a functional assessment across specified domains, showing significant impairment in three or more areas.
- ☐ - Complete a Level of Care Utilization System (LOCUS) assessment indicating a need for Level 5 care.
- ☐ - Demonstrate an ability to initiate or resume illness management and recovery skills/strategies, with supervision and focused treatment to enhance functioning and prevent relapse requiring higher care.
- ☐ - Show lack of response to active treatment at a less intensive level of care.
- ☐ - Require a restrictive setting and face significant functional decline without intensive residential treatment.
- ☐ Additionally, the recipient must have one or more of the following:
  - ☐ - History of two or more inpatient hospitalizations in the past year.
  - ☐ - Significant instability in independent living.
  - ☐ - Experience of homelessness.
  - ☐ - Increased alcohol and/or drug abuse.
  - ☐ - Frequent use of mental health services with poor outcomes in outpatient or community support settings.

**Must provide the following documents to ensure a comprehensive assessment and treatment planning:**

| |
|---|
| ☐ FA |
| ☐ DA |
| ☐ LOCUS |
| ☐ Hospital Records ( H&P, Admission Summary, Progress Notes) |
| ☐ Medication List |
| ☐ Face Sheet |

***Please offer further details on how the individual meets the criteria mentioned above and how they can receive optimal support through IRTS:***

- ***Please complete the form in its entirety and send all required documents to this email address:***
- *Info@libinprograms.org*