IRTS REFERRAL

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

Info@libinprograms.org 320-281-0008 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?

LIBIN PROGRAMS

IRTS REFERRAL

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

Info@libinprograms.org 320-281-0008 320-238-7682

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?

Functional Impairments (check ≥3 required):

- ☐ Self-care/ADLS
- ☐ Employment/education
- ☐ Housing stability
- ☐ Interpersonal relationships/social support
- ☐ Judgment/decision making
- ☐ Ability to manage psychiatric/medical symptoms
- ☐ Substance use impact

Clinical History (check ≥1 required)

- ☐ History of recurring or prolonged inpatient hospitalizations during the past year
- ☐ Significant independent living instability
- ☐ Homelessness
- ☐ Very frequent use of mental health and related services with poor outcomes for the individual

IRTS REFERRAL

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

Info@libinprograms.org 320-281-0008 320-238-7682

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 of er further details on how the individual meets the criteria mentioned above and how theycan receive optimal support through IRTS:

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