Referral for Intensive Residential Treatment Services
Please email completed form with service summary and assessment detail to:
irt@emeraldcity.health

REFERENT INFORMATION:

Date and Time of Referral: ______________________ Referent Name: ______________________

Contact Phone: ______________________ Contact Email: ______________________

Agency Name and Address: ____

Signature: ______________________

CONSUMER CONSENT:

Has the consumer agreed to be referred to the IRT program? ☐ Yes ☐ No

- If yes, please have the consumer sign a Release of Information allowing Managed Care organizations to receive the information on this referral and to share information with RI International's IRT Team
- If not, please obtain consent prior to submitting this form.

CONSUMER INFORMATION/DEMOGRAPHIC:

Consumer Legal Name: ______________________ DOB: _____ / ____ / ______ SSN: _____-____-______

Gender: ______________ Ethnicity: ______________ Preferred Language: ______________

ProviderOne Number: ______________________ Income (if known): ______________

Identified AFH/ALF/SNF (if already found): ______________________________

Address or Name of current location: ______________________________

Contact Number: ______________ Estimated Discharge Date: ______________

Legal Guardian*/DPOA Name and Contact Information: ______________________________

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** Please include any legal documentations for guardianship available with referral*

REFERRAL CHECKLIST: *Please include all necessary and listed documentation with referral form*

- Medical
  - ☐ Recent labs
  - ☐ Current medications
  - ☐ Mental health diagnosis
  - ☐ Medical history
- H&CS/DDA
  - ☐ CARES assessment
  - ☐ Service summary
  - ☐ Contracts for other care providers (e.g., ECS, SBS)
  - ☐ Any DDA assessments, when applicable
- If D/C from Hospital Referral
  - ☐ First & most recent psychosocial (minimum)
  - ☐ First & most recent psychiatric evaluation (minimum)
  - ☐ Recent progress notes
  - ☐ Any pertinent coordinator notes
  - ☐ Anticipated discharge date
  - ☐ Anticipated AFH/ALF/SNF placement
  - ☐ Discharge packet at discharge, including any scheduled appointments
- If Diversion Referral
  - ☐ Any of the above that's available, but MUST include
  - ☐ CARES assessment
  - ☐ Current care providers & best contact information (i.e., SBS, ECS, AFH, PCP)