



Community Foundations Referral Form

Client Name: _____ Referral Date: _____

Client Date of Birth: _____ Race: _____ Gender: Male Female Preferred Language: _____

Address: _____ Phone Number: _____

Social Security Number: _____ Insurance Type & Number: _____

Source(s) of income: SSI RSDI Other: _____ Amount(s): \$ _____ Assets: _____

Current Location: _____ County of Financial Responsibility: _____

Hospital S.W.: _____ Phone Number: _____

Case Manager: _____ Agency: _____

Phone: _____ Email: _____

Client Diagnosis

Primary Diagnosis:		ICD-10 Code:	
Secondary Diagnosis:		ICD-10 Code:	
Medical Conditions:			

Please complete all that apply. Attach relevant documentation as applicable.

		Most Recent Date(s)	Explanation
Medication Non Compliance	<input type="checkbox"/> Yes <input type="checkbox"/> No		
History of Violence to Persons or Property	<input type="checkbox"/> Yes <input type="checkbox"/> No		
High Vulnerability	<input type="checkbox"/> Yes <input type="checkbox"/> No		
History of Setting Fires	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sexual Issues/Aggression	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Drug/Alcohol Use or Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Legal Issues (including Unlawful Detainers)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Tenant Issues	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Convicted of Crime	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Reason for Referral (Please note that referrals are prioritized by clients who are in inpatient settings):

Has client had two or more hospitalizations in the last 24 months? Yes No

Has client had a continuous psychiatric hospitalization or residential treatment exceeding six months duration during the proceeding 12 months? Yes No

Commitment Information: Is client currently under a commitment order?

If yes, what type: Commitment Stayed Commitment Early Intervention Continuance or Dismissal

What is the discharge plan following treatment? What referrals are in place for this person following their IRTS placement? Please include date of referral.

Does this person have a housing subsidy? Yes No

Please attach most recent FA, DA, LOCUS, interpretative summary, and hospital records (if applicable) to referral.

Fax completed form to: (651) 225-1545 Contact Stacy Wedding at (651) 621-1784 or stacy.wedding@radiashealth.org for referral questions.

Community Foundations 1096 Gervais Ave Maplewood, MN 55109 (651) 221-9880