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: ____

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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	☐ Yes ☐ No		
History of Violence to Persons or Property	☐ Yes ☐ No		
High Vulnerability	☐ Yes ☐ No		
History of Setting Fires	☐ Yes ☐ No		
Sexual Issues/Aggression	☐ Yes ☐ No		
Drug/Alcohol Use or Abuse	☐ Yes ☐ No		
Legal Issues (including Unlawful Detainers)	☐ Yes ☐ No		
Tenant Issues	☐ Yes ☐ No		
Convicted of Crime	☐ Yes ☐ 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 us at 651-221-9880 or cfinfo@radiashealth.org for referral questions.

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