IRTS REFERRAL FORM

Referral Source Information

Name & Title:		Agency:
Phone Number:	E-mail address:	Relationship to Client:

Client Information

Personal Information

First Name:	M.I.:	Last Name:	Preferred Name:
Date of Birth:	Sex Assigned at Birth: ☐ Male ☐ Female ☐ Other	Gender Identity:	Ethnic Identity:
Address: ☐ Homeless		City:	Zip code:
Phone Number:	E-mail address:		SSN:

Legal Status & Legal Representative Contact Information

☐ responsible for self ☐ under commitment ☐ under guardianship **(complete section below)**		
First name:	Last name:	
Address:	City:	Zip code:
Best Contact Number:	Fax Number:	Email:

REQUIRED:

- **If the client is under guardianship, the legal document indicating this must be included.**
- **If the client is under commitment, the pre-petition screening, psychological examination, and commitment order must be included.**

Mental Health History

Mental Health Diagnoses:

Check all that apply:

- ☐ History of two or more mental health hospitalizations in the past year
- ☐ Significant independent living instability
- ☐ Homelessness
- ☐ Increased abuse of alcohol and/or drug use
- ☐ Poor outcomes in outpatient mental health and related services

Describe concerns indicated above:

History of suicidal/self-injurious behaviors? ☐ Yes ☐ No

If yes, please complete section below:

Past 3 Months	Behaviors	Lifetime
☐	Actual suicide attempt	☐
☐	Interrupted attempt	☐
☐	Self-aborted/Self-interrupted attempt	☐
☐	Other preparatory acts to kill self	☐
☐	Self-injurious behavior **WITHOUT** suicidal intent	☐

Description of behaviors:

History of aggression:

History of physical aggression? ☐ Yes ☐ No
If yes, describe:

Date of most recent incident:

History of verbal aggression? ☐ Yes ☐ No
If yes, describe:

History of property destruction/fire setting? ☐ Yes ☐ No
If yes, describe:

History of substance use? ☐ Yes ☐ No
If yes, describe:

Currently experiencing withdrawal symptoms? ☐ Yes ☐ No
If yes, describe:

History of overdose? ☐ Yes ☐ No
If yes, describe:

Medical Diagnosis/History

Medications

One of the following must be sent with the client (check the applicable box):

☐ A 30-day supply of medication

☐ A 3-day supply and a script for all prescribed medications

Current Medications

Medication & Dosage	Directions

Required:

☐ Prescriber has verified that prior authorizations for all prescribed medications have been approved

OR

☐ Prescriber has contacted pharmacy and verified that no prior authorizations are needed

Provider Name & Signature:	**Date:**

Standing Orders for Over-the-Counter Medications

Name:_____DOB:_____

Approved PRN medications:

Administration to occur per package instructions. Equivalent generic or store brands may be used.

- ☐ Tylenol/acetaminophen 325mg (regular strength)
- ☐ Tylenol Elixir/Acetaminophen Elixir
- ☐ Ibuprofen 200mg
- ☐ Baby Aspirin 81mg
  - must be approved by RN
- ☐ Sudafed PE (Phenylephrine HCL) 10mg
- ☐ Guaifenesin (liquid/pill form)
- ☐ Chloraseptic spray
- ☐ Throat lozenges/cough drops
- ☐ Milk of Magnesia
- ☐ Miralax (polyethylene glycol)
- ☐ Fleet Laxative (saline enema)
  – must be administered by RN/LPN
- ☐ Maalox (aluminium hydroxide)
- ☐ Mylanta
- ☐ Pepto-Bismol
- ☐ TUMS
- ☐ Debrox
- ☐ Imodium (loperamide) 2mg
- ☐ Benadryl (diphenhydramine hydrochloride) 25-50mg
- ☐ Hydrogen Peroxide
- ☐ Bacitracin Ointment
- ☐ Neosporin Ointment
- ☐ Calamine Lotion
- ☐ Sarna Anti-Itch Lotion
- ☐ Aloe Vera Gel
- ☐ Hydrocortisone Cream
- ☐ Lotrimin/Micatin/Tinactin Cream
- ☐ Selsun Blue Shampoo (selenium sulfide)
- ☐ Aveeno/Eucerin/Lubriderm Cream
- ☐ Campho-Phenique
- ☐ Chapstick/Blistex/Carmex
- ☐ Cankaid/Gly-Oxide
- ☐ Sunscreen (SPF15+)
- ☐ DEET insect repellent

Provider Signature:	**Date:**

Immunization Records

	Yes	No	Unknown		Yes	No	Unknown
Hepatitis A				HPV			
Hepatitis B				Flu			
MMR Tdap				Pneumonia			
Chickenpox				COVID-19 Vaccine			
				Other:			

Review of Systems

	Intervention Required?	Needs & Plan of Care:
Constitutional	☐ Yes ☐ No	
Neurological	☐ Yes ☐ No	
Eyes	☐ Yes ☐ No	
Skin	☐ Yes ☐ No	
Ears, Nose, Throat	☐ Yes ☐ No	
Respiratory	☐ Yes ☐ No	
Cardiovascular	☐ Yes ☐ No	
Gastrointestinal	☐ Yes ☐ No	
Genitourinary	☐ Yes ☐ No	
Musculoskeletal	☐ Yes ☐ No	
Hematologic	☐ Yes ☐ No	
Endocrine	☐ Yes ☐ No	
Integumentary	☐ Yes ☐ No	
Genitourinary	☐ Yes ☐ No	
Other	☐ Yes ☐ No	

Provider Signature:	**Date:**

Communicable Diseases:

☐ Yes
☐ No
If no, describe:

Physical/mobility issues:

Allergies:

Special Dietary Needs:

History of Surgeries:

Other Information Pertinent to Care:

Provider Signature:	**Date:**

Required Attachments:

☐ The client's eMAR, reviewed and signed on each page by a physician
☐ A copy of the client's most recent History & Physical

Other Attachments:

Copy of Commitment/Jarvis/Rule 20 Paperwork	☐ Attached	☐ Not Applicable
Discharge Paperwork	☐ Attached	☐ Not Applicable
Diabetic Assessment Form (pg. 9)	☐ Attached	☐ Not Applicable
Seizure Protocol Form (pg. 10 & 11)	☐ Attached	☐ Not Applicable
Upcoming Appointments Form	☐ Attached	☐ Not Applicable
Psychological/Diagnostic Assessment	☐ Attached	☐ None Available
Rule 25 Assessment	☐ Attached	☐ None Available

Referrals and copies of documents can be mailed or e-mailed (e-mail preferred) to:

1494 Delaware Ave, St Paul, MN 55118

E-mail: info.intake@metrocareservicesmn.com

Questions? Call 763-353-5466 or send an e-mail to the address listed above!

Any referrals who have a diagnosis of Diabetes MUST have this form completed and signed by a physician, in order to be admitted to our program.

Blood glucose readings for the past two weeks have been within normal limits (over 70 and less than 160)	☐ Yes ☐ No
If "No" was checked, how long has your facility monitored the patient's blood glucose readings?	
Patient has demonstrated they are able to complete glucometer readings, and is willing to complete readings at the recommended times.	☐ Yes ☐ No
Patient is willing to follow dietary recommendations to manage blood glucose levels.	☐ Yes ☐ No
Patient has completed diabetes education. Patient understands diagnosis and knows how to manage condition.	☐ Yes ☐ No

I _____ have assessed _____ and determined that
(Physician Name) (Patient Name)
they are fully able to self-monitor and comply with ALL aspects of their diabetic care with NO assistance from staff.

OR

I _____ have assessed _____ and determined that
(Physician Name) (Patient Name)
they can monitor their blood glucose levels with staff support, and does not need 24/7 medical care to manage their diabetes.

Provider Name & Signature:	**Date:**

Treating Physician:	Phone Number:

Seizure Type	Average Length	Frequency	Description
Triggers/Warning Signs:			
Symptoms After Seizures:			

Seizure First Aid	**Seizure Emergencies**
Metro Care Human Services staff are trained to respond to seizures with this process: • Track time • Move furniture or other objects out of the way • Place something soft under the person's head • Do not restrain or place objects in mouth • Roll the person onto their side if they are having trouble breathing because of vomiting or fluids in their mouth • Stay with the person until fully conscious • Record seizure Would you recommend this process be used for this patient? ☐ Yes ☐ No	Metro Care Human Services staff will consider a seizure an emergency if: • The person has never had a seizure before. • The person has difficulty breathing or waking after the seizure. • The seizure lasts longer than 5 minutes. • The person has another seizure soon after the first • one. • The person is hurt during the seizure. The seizure happens in water. The person has a health condition like diabetes, heart disease, or is pregnant. Would you recommend that this definition of a seizure emergency be used for this patient? ☐ Yes ☐ No
Other/additional procedures recommended:	Additional indications of an emergency, or other amendments to the definition above:

Provider Signature:	**Date:**

Seizure Emergency Protocol

☐ Call 911 for transport to: _____

☐ Administer emergency medications: _____

☐ Notify RN

☐ Notify primary care physician: _____

☐ Other: _____

_____

Daily Treatment Protocol		
Medication	Dosage & Administration Times	Common Side Effects & Special Instructions

Does the patient have a Vagus Nerve Stimulator (VNS)? ☐ Yes ☐ No

If yes, provide directions for use:

Recommended Safety Precautions:

Provider Signature:	**Date:**