PEOPLE INCORPORATED MENTAL HEALTH SERVICES

Intensive Residential Treatment Services Referral Form

***Please do not submit a referral if the client is not ready to admit to IRTS within the next 10 calendar days.

CLIENT'S DEMOGRAPHICS

First Name: ☐ Middle Initial: ☐ Last Name: ☐

D.O.B.: ☐ Gender: ☐ Identifying Gender: ☐

Address: ☐

City: ☐ State: ☐ Zip Code: ☐

County: ☐ Phone: ☐

Email Address (optional): ☐

Primary Language: ☐ Ethnicity: ☐

Race: ☐ Residential Status: ☐

Marital Status: ☐ Smoking Status: ☐

Country of Origin: ☐ Insurance: ☐ Insurance ID#: ☐

Sex Offender?: ☐ Yes ☐ No IF yes- Level: ☐

Mobility Issues: ☐ Can Complete ADL's ☐ Yes ☐ No

Diagnosis: ☐

REFERRING AGENT'S INFORMATION

Referent's Name: ☐ Title: ☐ Phone: ☐

Agency Name and Address: ☐

Is the client under your direct care and contact? ☐ Yes ☐ No

If no, provide current location of client: ☐
and attach ROI.

Please remember to send along the DA, ROI, Insurance information, H&P (from hospital) and Medication list. IRTS Intake staff will reach out within 72 hours of us receiving the information to complete a phone interview. Thank you!

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