Referral Application

Send all referrals to: Central Intake, 343 Wood Lake Drive SE, Rochester, MN 55904
Phone: 507-289-2089 Fax: 507-535-5799
Fax IRTS Referrals to: 507-535-5797

Date of Birth: ____________
Social Security #: ____________
Client Name: ________________________ **Gender:** ____________

Address: ____________ (Street) ____________ (City) ____________ (State) ____________ (Zip Code)

Client Phone: ____________ **Date of Referral:** Click here to enter a date.

Reason for Referral: ________________________

Describe Service Needs: ________________________

Referral Source/Agency: ________________________

Referral Address: ____________ (Street) ____________ (City) ____________ (State) ____________ (Zip Code)

Referral Source Phone Number: ____________ **Referral Source Email Address:** ____________

Commitment Status: ____________ **Legal Issues:** ____________
Stay of Commitment: ____________

Service Providers:	**Name:**	**Agency:**	**Phone Number:**
Guardian			
Representative Payee			
Psychiatrist			
Therapist			
Primary Care Provider			
Case Mgr./Social Worker			
Financial Worker			
Probation/Parole Officer			

- Assessment indicating a mental health diagnosis is required for IRTS referrals.
- Please attach current or recent notes/labs/medication list from current provider.
- Include current Release of Information.

Source of Income ☐ Social Security Income (SSI) ☐ Social Security Disability Income (SSDI) ☐ General Assistance ☐ Veteran's Administration (VA) ☐ Wage

Health Insurance Company: ____________ **County of Financial Responsibility:** ____________

Please check insurance type: ☐ Medicare ☐ Medicaid (MA) ☐ Commercial Insurance ☐ Employee Assistance Plan

Insurance ID # or Medical Assistance PMI#: ____________
Insurance Group Number: ____________