**Minnesota Specialty Health System Referral Questions**

*Recommendation is that you save this document. Navigate from field to field using the “Tab” key or a mouse.*

*Attach the completed form and email to* dhs.sos.centralpreadmissions@state.mn.us.

*If sending by fax, please send to 1-866-633-4253*

To avoid delays in placement decision please send any of the following paperwork that pertains to this referral:

* **All legal orders including Commitment, Criminal Rule 20, Jarvis, RPD, Guardianship/SDM, etc.**
* **Pre-petition screening and any petitions related to an order**
* **TBI Screening/MRI/CAT Scan if applicable**
* **Psychiatric assessment**
* **Psychological testing**
* **Rehab assessments (if applicable), medication records and proof of insurance**

Please note:

* MSHS sites are not locked/secure; clients cannot legally be prevented from leaving.
* Smoking is only allowed in specified areas on-site after 14 days from admission.
* Most admissions are scheduled for weekdays from 7am to 4:30pm.
* Priority placement is given to clients who are in jail and under civil commitment, or who are approved for competency attainment through the 611 processes.
* Focus of treatment is rehabilitation for mental health functional impairments.
* Client must demonstrate a clinical need for rehabilitative treatment in a 24-hour structured setting with supervision and have the willingness and ability to participate in rehabilitation.
* Client must be willing and able to participate in their treatment including Enhanced Illness Management and Recovery, Integrated Dual Diagnosis Treatment, Cognitive Behavioral Therapy, and family psychological education to foster social network.
* As with IRTS placement, client needs to have payment method set up for obtaining medications.
* Client must have diagnosis of serious mental illness.
* Client must be 18 years of age or older and free of communicable diseases.
* Accessibility for clients with physical limitations is assessed individually, to determine if the site can meet the client’s needs.
* If client has recently needed increased observation, seclusion, or restraints, they will need to show a period of time of improved safety prior to proceeding with placement.
* All clients must be medically and psychiatrically stable.
* A client must complete all detoxification prior to admission.
* MSHS sites are not skilled nursing facilities, therefore clients must be able to complete all activities of daily living.
* Clients required to register as a Predatory Offender will be reviewed by each site.
	+ Willmar MSHS has specific city laws regarding placement but can review cases.

Specific site information

* **Brainerd:** **Client must have a diagnosed/indication of a Traumatic/Acquired Brain Injury and paperwork needed, a TBI screening, and provide MRI or a CAT Scan relating to the TBI.**
* **Willmar:** For surrounding 18 counties (see list below) need to document denials to the 2 local IRTS facilities.

**Demographic Information:**

Date of Referral: Enter a date To which MSHS are you referring the patient to? Select site

Patient Name:       Medical Record Number:

SS Number:    -  -     DOB: Enter a date Age:       Gender:

Patient referred by:       Phone number:

Email address:       Fax number:

**Presenting Problem:**

What do you want the MSHS to work on while the patient is at MSHS; please list specific goals/reasons for MSHS placement?

What is the expected or preferred admission date? Enter a date

***Willmar MSHS only***

For referrals from the following 18 counties, prior to MSHS referral, please obtain denials from the 2 local IRTS and list dates (or cannot admit within a week): Unity House:       Brentwood:

1. Big Stone
2. Chippewa
3. Cottonwood
4. Jackson
5. Kandiyohi
6. Lac Qui Parle
7. Lincoln
8. Lyon
9. McLeod
10. Meeker
11. Murray
12. Nobles
13. Pipestone
14. Redwood
15. Renville
16. Rock
17. Swift
18. Yellow Medicine

Who should MSHS staff contact within 24-48 hours of referral to MSHS:

Telephone number:

What will the legal status be (*select all that apply*)?

[ ]  Civil Commitment Type (DD/MI/CD):

County of Commitment:

[ ]  Voluntary [ ]  Judicial Hold

[ ]  Provisional Discharge (Voluntary) [ ]  Stayed order of Commitment (Voluntary) [ ]  Rule 20 [ ]  Other:

Skills identified as an area of need (*please check all that apply*):

[ ]  Mental Health Symptoms Management in the community

[ ]  Interpersonal functioning

[ ]  Development of a community support system

[ ]  Vocational functioning

[ ]  Drug/Alcohol interaction with mental health

[ ]  Educational functioning

[ ]  Social functioning (including leisure)

[ ]  Financial functioning

[ ]  Self-care and independent living capacity

[ ]  Medical health management

[ ]  Dental health management

[ ]  Obtaining and maintaining housing

[ ]  Transportation use

[ ]  Other concerns:

**Contact Information:**

Patient’s Current Location:       Phone number:

Name of County Case Manager:       Phone number:

Email address:       Fax number:

Name of Probation Officer:       Phone number:

Email address:       Fax number:

Name of Guardian/SDM:       Phone number:

Email address:       Fax number:

Name of Rep Payee:       Phone number:

Email address:       Fax number:

**Funding/Insurance Information:**

County/Tribe of Finance?

What type of funding or insurance does the patient have?

Insurance Information please list type       (PMI) number:

Insurance Information please list type       (ID/Policy) number:

Insurance Information please list type       (Group) number:

Client has payment method set up for obtaining medications? [ ]  Yes [ ]  No

Insurance and co-pay Comments:

Name of Financial worker/team:       Phone number:

Email address:       Fax number:

**Health/Risk Information:**

Is the patient currently psychotic *(unable to engage in conversation)*? [ ]  Yes [ ]  No

Is the patient currently homicidal? [ ]  Yes [ ]  No [ ]  History of

Is the patient currently suicidal? [ ]  Yes [ ]  No [ ]  History of

Is the patient currently physically aggressive/assaultive? [ ]  Yes [ ]  No

Does the patient have a history of violent behaviors? [ ]  Yes [ ]  No

Does the patient have current involvement in the Adult or Juvenile Justice system? [ ]  Yes [ ]  No

Does the patient have any special needs? (ie: physical, medical, dietary, cultural, or interpreter needed)

[ ]  Yes [ ]  No If yes, what are they?

Prior psychiatric treatment:

Does the patient have any recent injuries? [ ]  Yes [ ]  No If yes, what are they?

Is the patient currently on a 1 to 1? [ ]  Yes [ ]  No

Is the patient free of communicable diseases? [ ]  Yes [ ]  No If no, which communicable diseases does the patient have?

Does the patient have any mobility limitations? [ ]  Yes [ ]  No Ambulatory care needed:

Is this client Pregnant? [ ]  Yes [ ]  No [ ]  N/A [ ]  Unknown

***Note any details known such as: Estimated date of conception (EDC), Estimated due date (EDD), etc.***

If yes, note any known details:

**Infection Disease Screening:**

Any foreign travel in the last 30 days? [ ]  Yes [ ]  No [ ]  I do not know

In the last 30 days has there been any exposure to known infectious diseases? [ ]  Yes [ ]  No [ ]  I do not know

Has the client ever tested positive for COVID-19? [ ]  Yes [ ]  No [ ]  I do not know

Date of positive COVID-19 test:

**MSHS Risk Questions:**

Does the patient have a history of suicidal ideation or suicide attempts? [ ]  Yes [ ]  No

Does the patient have a history of self-injurious behavior? [ ]  Yes [ ]  No

Current or history of ingestion or insertion of foreign objects? [ ]  Yes [ ]  No

Does the patient have a history of sexual aggression? [ ]  Yes [ ]  No

Does the patient have a history of Traumatic/acquired brain injury? [ ]  Yes [ ]  No

Any history of Developmental Disorder or low IQ and special education prior to age 18? [ ]  Yes [ ]  No

Does the patient have a history of fire setting? [ ]  Yes [ ]  No

Patient Diagnosis:

Chemical use history:

Additional Comments ***(explain any yes answers above, add details)***: