REQUEST FOR DYS TRANSFER TO A DMH INTENSIVE RESIDENTIAL TREATMENT PROGRAM

CLIENT INFORMATION

Client:	*Last Name* (Last)	*First Name* (First)	*MI* (MI)

Street Address:

City:

State: Zip Code:

DOB: Sex: Race: White Preferred Language:

Does Client Speak English?: Does Parent Speak English?:

Date of Admission to DYS facility:

Legal Status

☐ Committed Date Expired

☐ Youthful Offender Date Expired

☐ Dual Status ☐ Detained/On Bail

Expiration Date of DYS Commitment:

Name of DYS Case Worker: Telephone Number:

Guardianship

Does the patient have a court appointed legal guardian ? ☐ Yes ☐ No
(If Yes, attach copies of relevant guardianships, including Rogers Order.)

Name of Legal Guardian: Last Name First Name MI

Relationship to Client:

Street Address:

City: State: Zip Code:

Telephone #:

Has Parent/Guardian been consulted regarding IRTP referral? ☐ Yes ☐ No

Does Parent/Guardian support IRTP referral? ☐ Yes ☐ No

Health Insurance

☐ No health coverage
☐ Medicaid/MassHealth Card #: RID #:

MassHealth Provider ☐ HMO Name of HMO ☐ PCC ☐ Psych Under 21 ☐ Other

☐ Medicare
☐ Other Insurance Name of Insurance: Policy #:

Client:	*Last Name* (Last)	*First Name* (First)	*MI* (MI)

Name of Policy Holder:
Has eligibility for DMH continuing care services already been determined for this patient? ☐ Yes ☐ No

DYS FACILITY INFORMATION

Referring DYS Facility:
Name of Treating Clinician/Physician: Telephone:
Street Address:

City:

State: Zip Code:

INDEPENDENT EVALUATOR'S STATEMENT

I have reviewed the clinical criteria for referring individuals to a DMH intensive residential treatment program and believe this individual requires this level of continuing care treatment.

_____

Name of Evaluator Signature

Date:_____

Address & Telephone Number of Evaluator:

INSTRUCTIONS:

Please send this Transfer Request form and the following attachments to the Child/Adolescent Director of Program Management in the DMH Central Office.

1. Admission history ☐ Attached
2. Physical exam ☐ Attached
3. Psychiatric evaluation, including DSM-IV diagnoses (Axis I-V) ☐ Attached
4. Any other initial assessments (psychosocial, medication, etc.) ☐ Attached
5. Treatment course, including treatment plan, counseling and behavior management attempted, estimate of response to continued treatment, reason why any recommended treatments were not tried (if applicable) ☐ Attached
6. Last 10 days of progress notes ☐ Attached
7. Current medications; history, changes & rationale ☐ Attached
8. Copies of any relevant guardianships, including Rogers Order ☐ Attached