STRATEGIC INDIVIDUALIZED REMEDIATION TREATMENT (*STIRT*)
Residential Referral Form

Individual must be able to enter program for an Uninterrupted Three-week Residential stay followed by 24 to 49 weeks of Continuing Care Services. Residential and Continuing Care referrals should be made simultaneously to allow for better care coordination.

Program(s) Referred (may be sent to all three): ☐ **BTS -** STIRTreferral@btxs.org ☐ **Larimer CCC -** greaseem@co.larimer.co.us
☐ **Crossroads Men-**stirrt_m_referral@crossroadstp.org **or** ☐ **Crossroads Women-** stirrt_w_referral@crossroadstp.org

REFERRAL SOURCE INFORMATION

Referral Date:		Requested Admission Date:			Admission Date:				
Referring Agency:		Contact Person:			Position Title:				
Office Phone#:		Cell Phone#:		Fax #:	Email Address:				
PO/Case Manager Name:			Phone #:		Email address:				
Agency Type	☐ Parole	☐ Probation	☐ LSIP ☐ CCIP	☐ DOC Transition	☐ Recovery Court	☐ Veterans Court	☐ CommCorr	☐ Residential	☐ Other

INDIVIDUAL'S INFORMATION

Name ***(Last, First, M.I.):***			DOB:	SSN:
Phone #:	Email:	Resident District	Resident County	Resident City
Gender: ☐ Male ☐ Female ☐ Transgender ☐ Intersexual ☐ Chooses not to answer			☐ Other *(Explain)*	
Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Other *(Explain)*				
Residence City:	Custody Status: ☐ Incarcerated ☐ In Community			
Primary Drug of Choice:	Method(s) of Use:	Date of Last Use	Withdrawal Management Needed? ☐ Yes ☐ No	
Priority Population ☐ Yes ☐ No - https://drive.google.com/file/d/1c7KRvR19bcAPlEidml1ynxWBs2m-U7b6/view				
Pregnant: ☐ Yes ☐ No Woman with Dependent Children ☐ Yes ☐ No If yes, is youngest child under 12 months of age? ☐ Yes ☐ No				
IV Drug Use? ☐ Yes ☐	Drug Type:			

INDIVIDUAL'S QUALIFYING INFORMATION

To avoid delays in processing this application and individual's admission, all completed Assessment/Evaluation information (LSI, SSI, ASUS, TxRW, PSI, DOC, parole, probation, or other conditions of release paperwork must accompany this application.

ASUS Scores:	Involvement:	Disruption:	Social:	Mood/Emotion:	Defensive:	Global:	
Current LSI:	SSI:	TX Level (TxRW):	Has individual been in STIRT before? ☐ Yes ☐ No		Date:	Location:	
# Felony Convictions	Violent ☐ Yes ☐ No - Drug Related ☐ Yes ☐ No		# Misdemeanor Convictions		Drug Related ☐ Yes ☐ No - Violent ☐ Yes ☐ No		
Age at First Arrest:	Current Offense(s):				☐ Felony ☐ Misdemeanor		
Interstate Offender? ☐ Yes ☐ No	State(s)			Jurisdiction(s)			☐ Federal
Pending Court Case(s) ☐ Yes ☐ No	Details:						
Are there any currently active Medical and/or Dental Concerns? ☐ Yes ☐ No	Explain:						
Do any of these conditions require accommodation? ☐ Yes ☐ No	Explain:						
Will any of these conditions hinder the individual's ability to receive treatment? ☐ Yes ☐ No	Are there follow up/continuing appointments during the 3 weeks? ☐ Yes ☐ No						
Explain:							

STIRT programs are non-medical facilities and are not appropriate for Individuals with serious medical/dental needs.

Are there any currently active Psychiatric Conditions? ☐ Yes ☐ No	Explain:
Do any of these conditions require accommodation? ☐ Yes ☐ No	Will any of these conditions hinder the Individual's ability to receive treatment? ☐ Yes ☐ No
Explain:	

Individual must be free of overt psychiatric symptoms, and, if necessary, be stabilized on appropriate medications prior to referral. A three week supply of all necessary medications must accompany the individual, along with appropriate medical clearances for medication.
Please List ALL prescribed and over-the-counter medications, supplements, or devices – vitamins, inhalers, etc.

Name the Drug	Dosage	Frequency Taken

ALLERGIES TO FOODS OR MEDICATIONS

Name of Food or Drug	Allergic Reaction (s)

TREATMENT INFORMATION

Is Individual currently in treatment? ☐ Yes ☐ No	If Yes, Answer questions below. If No, when was the last time the Individual was in treatment?	
Program Name:	Contact Person:	Phone #:
Has this treatment provider been notified that a STIRT Referral has been made? ☐ Yes ☐ No		
Will individual be returning this program after completing STIRT Residential? ☐ Yes ☐ No		
If Individual is not currently in treatment or will not be returning to a current treatment setting, has a referral been completed for continuing care placement? ☐ Yes ☐ No		
Program Name:	Contact Person:	Phone #:

Please establish communication with Continuing Care program prior to the expected residential completion date.

Release of Information

My signature below hereby acknowledges consent to the release of information obtained by the above-named referring agency allowing communication between the above-named referring agency, and the above-named provider-agency.
I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

[date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent]. I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I have been provided a copy of this form.

Supervising Officer/Agent Signature	Date	Client Signature	Date

STRATEGIC INDIVIDUALIZED REMEDIATION TREATMENT (*STIRT*)
Community Continuing Care Referral Form

Referring Agencies

☐ Complete sections I and II for Initial referrals to STIRT Continuing Care Services.
Residential and Continuing Care referrals should be made simultaneously to allow for better care coordination.

☐ Complete sections I and III to transfer an Individual from one Continuing Care agency to another.

☐ Receiving agency must complete section IV Successful completion of a STIRT Residential program and/or prior engagement in STIRT Continuing Care services is required to qualify for STIRT funding.

Receiving Agencies

If you are accepting this continuing care referral please insure that all necessary sections of this form have been completed.
No other referral form will be accepted by the receiving agency or by the designated Managed Service Organization (MSO).
Please establish communication with residential program prior to the individual's anticipated completion date.

Section I - Individual's Information:

Individual Name: _____ DOB: _____ Phone: _____
Address: _____ City: _____
State: _____ ZIP: _____ Judicial District(s): _____

Section II – STIRT Residential Treatment Facility (Check one):

☐ Behavioral Treatment Services ☐ Crossroads TP ☐ Larimer County CC

Admission Date: _____ Discharge Date: _____
Contact Person: _____ Phone #: _____ Email: _____
Referral Agency: _____ Contact Person_____ Phone #: _____
Continuing Care Referral Date: _____ Date referral was sent: _____
Recommended Level of Care (Check one): ☐ OP ☐ EOP ☐ IOP ☐ Residential

Treatment Recommendations: _____
_____
_____

Section III – Continuing Care Services

Complete this Section if this individual has been receiving STIRT Continuing Care Services at your agency and is moving to a different OP program to continue STIRT Services.

Agency Name: _____ Contact Person: _____
Phone:_____ Email: _____
Admission Date: _____ Discharge Date: _____
Recommended Level of Care (Check one) ☐ OP ☐ EOP ☐ IOP ☐ Residential

Treatment Recommendations: _____
_____
_____
_____

Reason for transfer: _____
Referral Agency Name: _____ Contact Person: _____
Email: _____ Phone: _____ Transfer Date: _____

Section IV - Verification:

Completion of STIRT Residential Program and/or engagement in prior STIRT Continuing Care services has been verified.

☐ Residential Treatment ☐ Prior Continuing Care Services

Staff Signature: _____ Date Admitted: _____

Release of Information

My signature below hereby acknowledges consent to the release of information obtained by the above-named referring agency allowing communication between the above-named referring agency, and the above-named provider-agency.
I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

[date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent]. I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I have been provided a copy of this form.

Referral Agency Signature Date Client Signature Date