SunRise Retreat is a voluntary, short term (28-day max),12 bed Intensive Crisis Residential treatment service for those experiencing acute crisis or exacerbation of their mental health symptoms. Our goal is to provide a stable and healthy environment, that will assist individuals in their healing process.

At SunRise, the resident can expect:

- A comfortable community-based home like setting with individual rooms
- Individual and Group Counseling services
- Access to a medication provider, if necessary
- 24/7 professional staff

Admission Criteria

The Resident:

- Must be 21 years of age or older.
- Has a primary psychiatric diagnosis
- Be experiencing an acute psychiatric crisis and/or.
- Be experiencing challenges in daily life that create risk for an escalation of behavioral health symptoms and a loss of adult role functioning.
- Requires treatment service for stabilization of psychiatric symptoms.
- Requires 24-hour monitoring.
- Be medically stable.
- Is willing to participate in service voluntarily.
- Agrees to not be under the influence of alcohol or illicit drugs at the time of admission and for the duration of their treatment.
- Is willing to agree to program rules and regulations at the time of admission.
- Is willing to agree to personal item inventory and searches for safety of all residents and staff.

**Personal Vehicles are not authorized for use or to be on the premises while admitted to SunRise.

Please fill out the referral form and attach the requested documentation listed below. This packet can be emailed to Sunriseadmissions@riseservices.org for consideration.

Requested documentation:

- Recent mental health assessments
- Recent admission and/or discharge paperwork from hospitals/mental health inpatient settings.
- Recent lab work
- List of medications and providers.
- Releases (for referral agency and the client's emergency contact.

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REFERRAL FORM

Name:	Date:
Date of Birth:	Contact number:

Referring Agency/Agency Contact Name/Phone:

Insurance: Insurance ID:

Reason for Referral:

Current Mental Health Symptoms:

Primary Psychiatric Diagnosis:

Hospitalization History:

Medical Diagnosis:

Substance Abuse Diagnosis:

Last use:

Allergies:

History of Violence (Domestic or other) and/or aggression (if yes, please explain) ☐YES ☐NO

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Primary Care Doctor: (Name of Practice, Provider, Address. Phone Number)
Pharmacy: (Name, Address, Phone Number)
Therapist: (Name of Practice, Provider, Address, Phone Number)
Psychiatric Medication Provider: (Name of Practice, Provider, Address, Phone Number)
Case Manager: (Name of Agency, Name of Provider, Address, Phone Number, Email)
Specialty Doctors: (i.e. Cardiologist, Endocrinologist, Neurologist etc) (Name of Practice, Provider, Address, Phone Number)
Other agencies involved with the client: (i.e. Addiction Services, Rehabilitation providers, PROS etc)(Name of Agency, Provider, Address, Phone Number, Email)
Upcoming Appointments: (Name of Agency, Date/Time)