Nulton Diagnostic & Treatment Center
Referral for Adult Partial Hospitalization Program
110 Franklin Street, Suite 40, Johnstown PA 15901
(814) 410-2106

Clear Form

REFERRAL INFORMATION:

Name of Referral: Agency: Contact Number:

CLIENT INFORMATION:

Client Name: _____ Gender: ○ Male ○ Female

Date of Birth: _____ Grade: _____ Age: _____ Social Security Number: _____

Address: _____ Phone Number: _____

Does the Client have Medical Assistance: Yes ○ No ○ MA ID # _____ Card Issue # _____

Does the Client have other Medical Insurance: Yes ○ No ○ Type:_____ ID #_____

SERVICES ALREADY UTILIZED: (check all that apply)

☐ Mobile Therapy Agency: _____ Dates:_____ Currently seeing: ○ YES ○ NO
☐ Community ☐ Home

☐ Outpatient Therapy Agency:_____ Dates: _____ Currently seeing: ○ YES ○ NO
☐ Individual ☐ Family

☐ Case Management Agency: _____ Dates: _____ Currently seeing: ○ YES ○ NO

☐ Inpatient Hospitalization Agency: _____ Dates: _____ Currently inpatient: ○ YES ○ NO

☐ Out of Home Placement

☐ Supported Living Community Agency: _____Contact Person: _____ Phone: _____

☐ Residential Treatment Facility Agency: _____ Contact Person: _____ Phone: _____

☐ Psychotropic Medication Prescribed by: _____ Dates: _____

Medication Currently on: _____

☐ Other Services (please list) _____

REASON FOR REFERRAL:

Check any of the following apply:

☐ Disregard for authority ☐ Display or use of controlled substance

☐ Violent or threatening behavior ☐ Committing criminal activity

Other:

_____

_____

Referral Source Goals: (Please indicted expected measurement/outcomes of progress for the patient.)

Goal 1: _____
Goal 2: _____

Please send (via secure email, only) to: Tammie Baird tbaird@nulton.com OR FAX to (814)410-2108

Nulton Diagnostic & Treatment Center:

Date received: _____ Psychosocial Scheduled With/Date: _____

Psychiatric Scheduled With/Date: _____ Tentative Start Date: _____