NULTON DIAGNOSTIC & TREATMENT CENTER
1-888-918-5465

Referral for Services

Bedford, Somerset, and Cambria Children's Programs - (814) 624-3121

CLIENT INFORMATION:

Client Name: _____ Gender: ☐ Male ☐ Female

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

Address: _____ City: _____ State: _____ Zip: _____

County: ☐ Bedford ☐ Somerset ☐ Cambria ☐ Other: _____

Parent/Guardian Name: _____ Relationship to Client: _____

Parent/Guardian Phone Number: Home: _____ Cell: _____

Other: _____

Does the child have Medical Assistance: ☐ Yes ☐ No MA ID #: _____ Card Issue #: _____

Does the child have other Medical Insurance: ☐ Yes ☐ No Type: _____ ID #: _____

SERVICES BEING REQUESTED*:

☐ Functional Family Therapy (FFT) ☐ Partial Hospitalization Program ☐ Brief Treatment (Bedford/Somerset only)

☐ Psychological Evaluation ☐ Psychiatric Evaluation ☐ Outpatient Therapy

☐ School Outpatient Therapy

**To refer for Family Based Mental Health Services, please contact the FBMHS office at (814) 266-4777*

SERVICES ALREADY UTILIZED: (check *all* that apply)

☐ MT/BSC/TSS Agency: _____ Dates: _____ Currently seeing: ☐ YES ☐ NO

☐ School ☐ Community ☐ Home Therapist Name: _____

☐ Outpatient Therapy Agency: _____ Dates: _____ Currently seeing: ☐ YES ☐ NO

☐ Individual ☐ Family Therapist Name: _____

☐ Family Based Agency: _____ Dates: _____ Currently seeing: ☐ YES ☐ NO

Therapist Name: _____

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

Case Manager Name: _____

☐ Hospitalization Facility: _____ Dates: _____ Currently seeing: ☐ YES ☐ NO

☐ Partial Hospitalization Facility: _____ Dates: _____ Currently seeing: ☐ YES ☐ NO

Contact Person: _____ Phone: _____

☐ Out of Home Placement

☐ Therapeutic Foster Care/CRR Agency Name: _____

Contact Person: _____ Phone: _____

☐ Residential Treatment Facility Agency: _____

Contact Person: _____ Phone: _____

☐ Psychotropic Medication Physician Name: _____ Dates: _____

Medication(s) Currently on: _____

☐ CYS Involvement - Case Manager: _____ ☐ JPO Involvement - Case Manager: _____

☐ Other Services (please list): _____

SCHOOL INFORMATION:

School District: _____ School Name: _____
Address: _____ City: _____
State: _____ Zip: _____ County: _____
Name of Contact Person at School: _____
School Phone Number: _____ Fax: _____ Email: _____
Has the child ever received any of the following:

☐ Detention ☐ In-School Suspension ☐ Out-of-School Suspension ☐ Expelled ☐ Out of School Placement

Comments: _____

School Attendance: ☐ Regular ☐ Sporadic ☐ Rarely Attends In the last 30 days how many days absent: _____

School Performance: ☐ Above-Average ☐ Average ☐ Below-Average ☐ Failing

School Behavior: ☐ No Behavior Problem ☐ Occasional Behavior Problem ☐ Constant Behavior Problem

Comments: _____

Does the Student have an IEP: ☐ Yes ☐ No Date of last update: _____ *Please include IEP with this referral*

Note: Children with an IEP entering into our PHP Program will have an IEP meeting scheduled 10 days following placement.

REFERRAL SOURCE:

Today's date (date of referral): _____ Name of person referring: _____
Agency: _____
Phone Number: _____ Alternate Phone Number: _____
Address: _____

Note: If an Inter-Service Planning Team (ISPT) meeting is required prior to beginning a recommended service, the referral source will receive an invitation requesting participation.

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 ☐ Misconduct that merits suspension or expulsion ☐ Habitual truancy

☐ Other: _____

_____

Referral Source Goals:

Goal 1: _____
Goal 2: _____
Goal 3: _____

*Please FAX this form to **814-624-2403** or send (via secure email only) to:*
alaird@nulton.com, lleydig@nulton.com or kcalhoun@nulton.com

Nulton Diagnostic & Treatment Center Use Only:

Date referral received by NDTC: _____
Psychosocial Evaluation Scheduled: Date _____ Evaluator Name: _____
Psychiatric Scheduled: Date _____ Evaluator Name: _____
Tentative Service: _____ Tentative Start Date: _____
Notes: _____