Nulton Diagnostic & Treatment Center

1-888-918-5465

OUTPATIENT REFERRAL FORM
(COUNSELING AND MEDICATION MANAGEMENT)

EMAIL:SCHEDULING@NULTON.COM
PHONE: 814-846-5120 FAX: 814-419-8276

Patient Name: ______________________________

Guardian(s): ______________________________

Date of Birth: _____ / _____ / _____

Address: ______________________________

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Email: ______________________________

Mobile: ____________________ ***Home:*** ____________________

Patient insurance #1 and ID number: ______________________________

Subscriber name: ______________________________

Date of Birth: _____ / _____ / _____

Patient insurance #2 and ID number: ______________________________
(IF APPLICABLE)

Subscriber name: ______________________________

Date of Birth: _____ / _____ / _____

REASON FOR REFERRAL:

- ○ REQUESTING COUNSELING
- ○ REQUESTING DIAGNOSTIC EVALUATION
- ○ REQUESTING PSYCHIATRIC SERVICES INCLUDING MEDICATION MANAGEMENT
- ○ OTHER: ____________________

Are current behavioral health services being received? ○ YES ○ NO
If yes, please describe Behavioral Health services current being received:

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Are Behavioral Health medications being taken? ○ YES ○ NO
If yes, please list provider of medications.

Provider: ____

Current medication list: ____

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Please list previous Behavioral Health Treatments.

PREVIOUS INPATIENT PSYCHIATRIC HOSPITALIZATIONS
(MOST RECENT HOSPITALIZATION, TOTAL NUMBER, REASONS FOR ADMISSION, LOCATION OF HOSPITALIZATION)

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PREVIOUS LONG-TERM TREATMENT
(RTF, RTF-A, LTSR, STATE HOSPITAL, DAS)

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PREVIOUS OUTPATIENT TREATMENT
(IOP, PHP, COUNSELING, MEDICATION MANAGEMENT, FAMILY-BASED SERVICES, MOBILE THERAPY)

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PREVIOUS ADDITIONAL SERVICES
CASE MANAGEMENT, PEER SUPPORT, OTHER

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