Nulton Diagnostic & Treatment Center, PC
220 College Park Plaza
Johnstown, PA 15904 (814) 266-4777

Family Based Mental Health Services Referral Form

IDENTIFYING INFORMATION			
Child's Name:	Date of Birth/Age:	Gender:	Race:
Address:	Phone:	Social Security Number:	
County:	Insurance:	MA Number:	

REFERRAL INFORMATION

Referral Source: **Contact Person:** **Phone:**

Psychiatrist/Psychologist: **Phone:**

DIAGNOSTIC IMPRESSIONS	
Primary:	
Secondary:	
Psychosocial Stressors:	
GAF:	
Outpatient MH treatment is inappropriate or insufficient to meet the needs of the CHILD because: (must be completed)	

☐ **Suicidal/homicidal ideation/self-injurious behavior**	☐ **Psychosocial functional impairment**
☐ **Impulsivity and/or aggression**	☐ **Thought impairment**
☐ **Affection/function impairment (i.e. withdrawn, reclusive, labile)**	☐ **Cognitive impairment**
☐ **Psychomotor retardation or excitation**	☐ **Substance abuse**
☐ **Trauma**	☐ **SED*** If present, describe in detail below:**

☐ Psycho-physiological condition (i.e., bulimia, anorexia nervosa)	

RISK

Is child at risk for out-of-home placement? ☐ Yes ☐ No If yes, explain: Has the child ever been placed out of the home? ☐ Yes ☐ No If yes, explain:	At risk for what type of out-of-home placement? ☐ Psychiatric hospitalization ☐ RTF ☐ Foster care ☐ Juvenile Court Placement ☐ Other (Please specify)

FAMILY INFORMATION

Legal Guardian(s) Relationship:	Biological Mother:	Biological Father:
Address:	Address:	Address:
Phone:	Phone:	Phone:

Other mental health services in the household?	Which family members are they working with?

Others living in household Last Name First Name	Relationship to the child

Describe detailed information regarding psychiatric symptoms/behavior problems/significant psychosocial stressors that may interfere with child/family function in the home:

Previous and Current Mental Health Treatment of member	Dates	Facility/Provider
☐ ICM/RC or Blended Case Management		
☐ Outpatient		
☐ Partial		
☐ BHRS (Wraparound)		
☐ Family Based		
☐ Psychiatric Hospitalization		
☐ RTF or CRR ☐ Other		

CURRENT MEDICATION

Name	Dose	Frequency

Any medical concerns:		
School/Grade/IEP?:		
Has the child had a physical examination in the past 12 months?	☐ **Yes** ☐ **No**	
Has the child had psychiatric/psychological evaluation in the past 6 months?	☐ **Yes** ☐ **No** ☐ **Unknown** **If yes, date of eval:**	
FAMILY STRENGTHS (include individual strengths, family strengths, natural supports and community linkages)		
CHILD/ADOLESCENT: **FAMILY:**		
Is the child returning home from an out-of-home placement and FBMHS is needed as a step-down? If yes, please describe. ☐ **Yes** ☐ **No**		

Please FAX completed form to: Nulton Diagnostic & Treatment Center FBMHS 814-266-7077