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

Referral for Services
Bedford, Blair, Cambria, and Somerset Children's Programs

CLIENT INFORMATION:

Client Name: _____ Gender: ☐ Male ☐ Female

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

Address: _____

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

Parent/Guardian 1: _____ Relationship to child: _____

Address: _____

Main Phone: _____ Alternate Phone: _____

Parent/Guardian 2: _____ Relationship to child: _____

Address: _____

Main Phone: _____ Alternate Phone: _____

Other Guardian information*: _____

**Please indicate if there is shared custody or if custody is other than parent(s), as well as name of legal guardian.*

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

Child has Primary Care Physician: ☐ Yes ☐ No Physician/Practice Name: _____

SERVICES BEING REQUESTED*:

☐ School Outpatient Therapy ☐ Partial Hospitalization Program

☐ Psychological Evaluation ☐ Psychiatric Evaluation ☐ Outpatient Trauma Therapy

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

CURRENT AND PAST SERVICES ALREADY UTILIZED: (check *all* that apply)

☐ MT/BSC/TSS Agency: _____ Dates: _____ Currently seeing: ☐ Yes ☐ No

☐ School ☐ Community ☐ Home Contact Name: _____

☐ Outpatient Therapy Agency: _____ Dates: _____ Currently seeing: ☐ Yes ☐ No

☐ Individual ☐ Family ☐ Group Contact Name: _____

☐ Family Based Agency: _____ Dates: _____ Currently seeing: ☐ Yes ☐ No

Therapist/Contact Name(s): _____

☐ Case Management Agency: _____ Dates: _____ Currently seeing: ☐ Yes ☐ No

Case Manager/Contact Name(s): _____

☐ Hospitalization Facility: _____ Dates: _____ Currently seeing: ☐ Yes ☐ No

Other hospitalizations (if applicable): _____

☐ Partial Hospitalization Agency: _____ Dates: _____ Currently seeing: ☐ Yes ☐ No

Contact Name: _____

☐ Foster Care/CRR Agency: _____ Dates: _____ Currently seeing: ☐ Yes ☐ No

Contact Name: _____

☐ Residential Treatment Agency: _____ Dates: _____ Currently seeing: ☐ Yes ☐ No

Contact Name: _____

☐ Psychotropic Medication Agency: _____ Dates: _____ Currently seeing: ☐ Yes ☐ No

Physician Name: _____ Current Medications: _____

Child's Name: _____ *DOB:* _____

☐ CYS Involvement-Case manager: ☐ JPO Involvement – Case Manager:

☐ Other Services (please list):

SCHOOL INFORMATION:

School District: School Name:

Address:

County: Name of Contact Person at School:

School Phone Number: Fax: Email:

Attendance: ☐ Regular ☐ Sporadic ☐ Rarely Attends # Days missed in last 30 days

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

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

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

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 may 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 be invited to participate.

REASON FOR REFERRAL:

Check all of the following that apply:

☐ Mental Health Concerns Please describe:

☐ Disregard for authority ☐ Display or use of controlled substance ☐ Committing criminal activity

☐ Violent or threatening behavior ☐ Misconduct that merits suspension ☐ Habitual truancy

Other:

Referral Source Goals:

*Please FAX this form to **814-624-2403** or send (via secure email only) to:*
susan.custer@nulton.com, anorris@nulton.com or shayes@nulton.com

Nulton Diagnostic & Treatment Center Use Only:

Date referral received by NDTC: *Received by (name):*

Psychological Evaluation Scheduled: *Date:* *Evaluator Name:*

Psychiatric Evaluation Scheduled: *Date:* *Doctor Name:*

Tentative Service(s): *Tentative Start Date:*

Notes: