NULTON DIAGNOSTIC & TREATMENT CENTER

County:_____

Referral Form – Adult Mobile Mental Health Treatment
Phone: 814-361-2077 Fax: 814-254-4630

Date of Call:_____
Referral Information:

Name of Caller:_____ Phone:_____

Type of Referral: Self Agency Physician Family/Friend Other:_____

Facility/Agency/Physician Making Referral:_____

Name **(with middle initial)**:_____Phone:_____

D.O.B:_____Insurance:_____SS#:_____

Address:_____

Directions to Home:_____

_____

Physician:_____ Phone:_____ Last Medical Exam:_____

Psychiatrist:_____ Phone:_____ Last Psychiatric Evaluation:_____

Diagnosis:_____

Reason For Referral**:** _____

_____

Comments:_____

History of Substance Abuse? Yes:_____ No

Treatment History: Inpatient Psychiatric:_____ D&A Inpt:_____

History of Incarceration or Parole? No Yes:_____

Current Medications:_____

Other Agencies/Services Client is Receiving:_____

Does patient have a history of trauma? No Yes:_____

If Yes, Action Taken:_____ Referred To:_____

Medical Necessity Criteria for Mobile Mental Health Therapy

Please check the criteria that applies to the person you are referring:

_____ Medical condition, as documented in the treatment plan, that impairs the ability of the individual to participate or precludes the individual from participating in psychiatric outpatient clinic services. _____

____ Psychiatric condition, as documented in the treatment plan, that impairs the ability of the individual to participate or precludes the individual from participating in psychiatric outpatient clinic services. _____

____ One or more significant psychosocial stressors, as documented in the treatment plan, that impairs the ability of the individual to participate or precludes the individual from participating in psychiatric outpatient clinic services.

AND

_____ Individual must agree to participate in Mobile Mental Health Treatment, be 21 years of age or older, and have Medical Assistance.

Action Taken:

Talked to Client (date):_____ Called and left message (date/s):_____

Called Physician for Order (date/s):_____ Client needs to see a primary care physician

No Primary Care Physician Client does not meet criteria for mobile therapy

Referred to Another Agency/Service:_____

Physician's order received: (date):_____ Date of Physician's order:_____

Appointment Scheduled:_____ Provider:_____