Name:
DOB:

Intensive Behavioral Health Services Referral Form

IDENTIFYING INFORMATION			
Child's Name:	Date of Birth/Age:	Gender:	Race:
Address: Phone:		SS#:	
Residing with (name and relationship):		School (if applicable):	
County:	Insurance:	MA Number:	

REFERRAL INFORMATION

Referral Source: Contact Person: Phone:
Referral Date:
Psychiatrist/Psychologist: Phone:

Current Mental Health Diagnosis	
ICD-10-CM code	Description

Presenting Concerns/Comments:

Please check all that apply:

☐ Suicidal/homicidal ideation/self-injurious behavior	☐ Developmental Delays
☐ Impulsivity and/or aggression	☐ Sleep Problems
☐ Hyperactivity	☐ Cognitive impairment
☐ Inattentiveness	☐ Substance Abuse
☐ Trauma	☐ Defiance
☐ Autism Spectrum Disorder	☐ Anxiety/Depression
☐ Eating/Feeding Problems	☐ Other:

FAMILY INFORMATION

Name:
DOB:

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

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

Others living in household
(Please include name, age and relationship to child)

Previous and Current Mental Health Treatment:

☐ ICM/RC or Blended Case Management		Facility/Provider
☐ Outpatient		
☐ Partial Hospitalization		
☐ Family Based		
☐ Psychiatric Hospitalization		
☐ RTF or CRR		
☐ Other		

CURRENT MEDICATION

Name	Dose	Frequency

Any medical concerns:

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:

Fax Completed Form to **814-266-2880** or Email to **ibhs@nulton.com**