

Neurodevelopmental Center

integrated care for youth & families

CLIENT NAME:		D.O.B:	
PARENT/GUARDIAN NAME:		DCS INVOLVEMENT: Y N	
PHONE NUMBER: HOME: _____ CELL: _____		NAME OF PRIMARY CARE PROVIDER: _____	
INTERPRETER NEEDED: YES NO LANGUAGE: _____			
PARENT/GUARDIAN EMAIL ADDRESS:			
STREET ADDRESS:			
CITY:		STATE:	ZIP:
TYPE OF INSURANCE:		REFERRAL SOURCE:	
<p>NDC Eligibility Criteria: Child (0-17yo) must be an Indiana resident who has a suspected/established diagnosis of a mental health concern AND a suspected/established diagnosis of Autism Spectrum Disorder/developmental disability or intellectual disability.</p> <p>List concerns and/or providers who have diagnosed the selected option(s)</p> <p><input type="checkbox"/> Suspected/diagnosed mental health concern: _____</p> <p>_____</p> <p><input type="checkbox"/> Suspected/diagnosed Autism Spectrum Disorder: _____</p> <p>_____</p> <p><input type="checkbox"/> Suspected/diagnosed Intellectual Disability: _____</p> <p>_____</p>			
<p>PRIOR/CURRENT SERVICES: (check all that apply, name the provider of the service, and specify dates of the service)</p> <p><input type="checkbox"/> Occupational therapy, provider _____</p> <p><input type="checkbox"/> Physical therapy, provider _____</p> <p><input type="checkbox"/> Mental health therapy, provider _____</p> <p><input type="checkbox"/> Speech therapy, provider _____</p> <p><input type="checkbox"/> Psychological evaluation, provider _____</p> <p><input type="checkbox"/> Psychiatric Services, provider _____</p> <p><input type="checkbox"/> Specialty Medical Services, provider _____</p> <p><input type="checkbox"/> First Steps _____</p>			
PLEASE INCLUDE RECORDS FROM ANY OF THE ABOVE INDICATED SERVICE PROVIDERS			
NAME OF PERSON COMPLETING THIS FORM:		DATE:	
PHONE NUMBER:			
EMAIL ADDRESS:			

Please send completed referral form to: ndc@southwestern.org

Phone number: (812) 436-4387