Neurodevelopmental Center of Southwestern Indiana
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 ADDESS:	
STREET ADDRESS:	

CITY:	STATE:	ZIP:

TYPE OF INSURANCE:	REFERRAL SOURCE:

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.

List concerns and/or providers who have diagnosed the selected option(s)

☐ Suspected/diagnosed mental health concern: _____

_____

☐ Suspected/diagnosed Autism Spectrum Disorder: _____

_____

☐ Suspected/diagnosed Intellectual Disability:_____

_____

PRIOR/CURRENT SERVICES: (check all that apply, name the provider of the service, and specify dates of the service)

- ☐ Occupational therapy, provider_____
- ☐ Physical therapy, provider_____
- ☐ Mental health therapy, provider_____
- ☐ Speech therapy, provider _____
- ☐ Psychological evaluation, provider_____
- ☐ Psychiatric Services, provider _____
- ☐ Specialty Medical Services, provider _____
- ☐ First Steps _____

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