



**Consultation Request Form - Neurodevelopmental and Behavioral Center
Developmental Pediatrics/Child Development/Behavioral Pediatrics**

To be used for non-urgent referrals only. For urgent concerns, please contact our office at 317-944-4846. Fax completed form along with the required documentation to 317-944-9760. Upon acceptance of the referral, we will make one attempt to call the family. If unable to reach the family, we will mail them a letter (with a copy to your office) asking them to contact us to schedule. We will notify you via fax if a referral is not accepted for any reason. We will notify you via fax when the patient is scheduled.

Required Documentation:			
<ul style="list-style-type: none"> ➤ Notes from the two most recent office visits pertaining to this issue ➤ Copy of front and back of patient's insurance card – not required if patient's primary insurance is Indiana Medicaid ➤ Growth Charts (length, weight and OFC) 			
Suggested Documentation:			
To provide your patient with the most complete evaluation, please include the following documents with your referral if available:			
<ul style="list-style-type: none"> ➤ Birth records ➤ Results of recent hearing or vision screens ➤ Relevant lab or study results (Lead, CBC, chromosomes, MRI, etc.) ➤ Results of any developmental testing/screening that has been performed (ASQ, M-CHAT) ➤ Copy of most recent developmental or educational evaluation (First Steps IFSP, School IEP, Testing results) 			
Patient Information ***All fields must be complete and legible***			
Today's Date:		IU Health MRN:	
Patient Name:			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB:	Age:	Race/Ethnicity:
Patient's Address:			
City:	State:	Zip Code:	County:
Caregiver's Name:		Relationship to Patient:	
Primary Phone #:		Alternate Phone #:	
Insurance Information			
Primary Insurance Company:		Policy/Member #:	
Policy Holder Name:		Precertification Phone #:	
Consultation Request (attach additional sheet if needed to provide adequate detail)			
In order to help us identify the best service for your patient, please list any current diagnoses and provide a detailed description of the reason for the referral, including specific behaviors of concern and any diagnoses you would like to have evaluated.			
If child is under 3, has an M-CHAT been done? <input type="checkbox"/> Yes <input type="checkbox"/> No		If child is under 5, has an ASQ been done? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this patient require an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, language needed:	
If you are requesting a specific provider, please indicate the name here:			
Referring Provider Information			
Provider Name:		<input type="checkbox"/> Primary Care Physician <input type="checkbox"/> Specialist:	
Office Phone Number:	Office Fax Number:	Contact Person:	

You should receive a fax copy of our communication to the family within 3 to 5 business days of your referral. If you have not heard from us within 5 business days, please call 317-944-4846 to confirm that your referral was received.