

**NEURODEVELOPMENTAL CENTER OF EXCELLENCE
REFERRAL FORM**

REFERRAL DATE:	
REFERRAL SOURCE:	

REFERRAL CRITERIA	
Was the child exposed to lead?	
Is the child between the ages of 3 and 26?	
Has the child graduated high school?	
Did the child live in the city of Flint between April 2014 and January 2016 when he/she was exposed to lead?	

CHILD INFORMATION	
Child's First Name:	
Child's Last Name:	
Child's Medicaid Number:	
Child's SSN:	
Child's DOB:	
Child's Address:	

DEMOGRAPHICS	
Gender:	
Race(s):	1) 2) 3)
Hispanic/Latino Origin:	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes,
Primary Language:	

NEURODEVELOPMENTAL CENTER OF EXCELLENCE REFERRAL FORM

CAREGIVER INFORMATION	
Caregiver/legal guardian:	
Relationship to Child:	
Caregiver/legal guardian address:	
Contact Phone Number:	

ADDITIONAL INFORMATION	
School Name:	
School contact number:	
Primary Care Provider (PCP):	
PCP contact number:	
Other Pertinent Providers & contact numbers:	

Please fax referral sheet, along with any other documents (School records/IEP, psychological evaluations, previous medical evaluations such as from neurologist, etc.) that may be of benefit to assist in the evaluation process to (810)257-3757. Thank you.

GHS Neurodevelopmental Center of Excellence
2700 Robert T. Longway, Suite H
Flint, MI 48503
Phone: (810)496-5677
Fax: (810)257-3757