

SURVEY OF SERVICES PROVIDED

Name of Provider: _____

Facility Name (if applicable): _____

Provider NPI: _____

Contact Name, including telephone number and email: _____

Age Groups Treated: _____

Please check the boxes for specialty services delivered:

- | | |
|---|--|
| <input type="checkbox"/> Autism | <input type="checkbox"/> General Psychiatry |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Generational Trauma |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> LGBTQ+ |
| <input type="checkbox"/> Complex Medical Issues | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> Co-Occurring Mental Health & Substance Use | <input type="checkbox"/> Pervasive Developmental disorders |
| <input type="checkbox"/> Deafness & Hearing Impairments | <input type="checkbox"/> Post Traumatic Stress Disorder |
| <input type="checkbox"/> Dual Diagnosis (IDD/DD) | <input type="checkbox"/> Sexual Offenders |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Sexually Reactive Disorders |
| <input type="checkbox"/> Early Onset Schizophrenia | <input type="checkbox"/> Sexual Assault and Sexual Trafficking |
| <input type="checkbox"/> Fetal Alcohol Syndrome | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Full Scale IQ Between 48-80 | <input type="checkbox"/> Gender specific treatment |
| <input type="checkbox"/> Other (please specify) | |

Are you ever involved in discharge planning discussions with a PT 63 Residential Treatment Center provider who is preparing to discharge a youth? _____

Please identify any care coordination and discharge planning done with other community agencies (i.e., housing, juvenile justice & specialty courts, social services, transportation, etc.):

Email the completed survey to BehavioralHealth@dncfp.nv.gov with subject line: Provider Survey