UNIVERSITY OF
SOUTH DAKOTA
SANFORD SCHOOL OF MEDICINE
Center for Disabilities

A University Center for Excellence in Developmental Disabilities Education, Research and Service

Fetal Alcohol Spectrum Disorders Clinic Consultation, Training and Technical Assistance
Intake Form

Today's date_____

Please complete the form to the best of your ability. All information requested is important, but we realize you may not have access to all the answers or some may be non-applicable (NA).

Please provide the following information about the individual being referred.

Individual's Name _____ gender: ☐ F ☐ M
First *Middle* *Last*

ETHNICITY/RACE (check all that apply)

☐ White ☐ Black ☐ Native American/ Alaska Native

☐ Asian ☐ Native Hawaiian/ Other Pacific Islander ☐ Other

☐ Considers themselves Hispanic or Latino

Social Security Number _____ Date of Birth _____ Age _____

Parent(s)/Legal Guardian(s) _____

Are you the legal guardian? ☐ Yes ☐ No If no, please provide the name and phone number of the legal guardian:

_____

Address _____
(Street or PO Box) *(City/State)* *(Zip Code)*

Home Phone _____ Cell phone _____ E-mail _____

School/Preschool/Headstart/Birth to 3/Agency Name_____

Attendance Center _____

Attendance Center/Agency Address_____
(Mailing Address) *(City/State)* *(Zip Code)*

Individual's Grade/Program _____

Contact Person at School/Agency _____Title _____

Phone_____ Fax_____ E-mail _____

To whom should we send correspondence about the individual?

Individual's name _____

Relationship to individual: ☐ birth, ☐ adoptive or ☐ foster parent ☐ other (specify_____)

Address _____
(Street or PO Box) *(City/State)* *(Zip Code)*

Home phone _____ Work phone_____ E-mail _____

Presenting Concerns (Complete those that are relevant)

Reason for Referral

Academic/Vocational

Behavioral

Communication

Medical

Motor (gross and fine)

Social

Other

Desired Outcome of Consultation

Individual Information (Please answer the following questions with regard to the individual being referred)

List any medications, vitamins, or supplements the individual is currently taking and dosage(s).

Please list current/previous diagnoses made concerning this individual.

When were the current/previous diagnoses made?

Who made the current/previous diagnoses? (Please include the doctor's/ clinic address and phone number if possible)

What educational programming is in place for this individual?

What strategies have you found to be the most helpful when working with this individual?

Has this individual been seen previously by Center for Disabilities personnel? Yes ☐ No ☐

If yes, date individual was seen _____

Services Requested (Check all that apply):

☐ Consultation (FASD consultant provides on-site observation and recommendations to school/agency/home)

☐ Inservice (FASD consultant provides on-site training for staff and/or family)

☐ Other (Please specify) _____

Payment of Services

Cost of services will be covered by: School District ☐ Parents ☐ Agency ☐

Were parents/guardians contacted regarding this referral? Yes ☐ No ☐
Have they agreed to this referral? Yes ☐ No ☐
Was the individual's school/agency contacted regarding this referral? Yes No

PLEASE NOTE:

Please include the following information as it applies to this individual:

- ***Current IEP/IFSP/IHP***
- ***Most recent Special Education Evaluation***

_____ _____
Signature of person completing this form Date