**LAC+USC VIOLENCE INTERVENTION PROGRAM**

**FETAL ALCHOL SPECTRUM DISORDER CLINIC**

2010 Zonal Avenue #3P61 Los Angeles CA 90033

323.409.5086 Office | 323.226.4403 Fax

**NON-DCFS/OUT-OF-COUNTY REFERRAL INTAKE FORM**

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| **CLIENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Patient Name: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | |  | | | | | | | | |
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| Previous Name (AKA): | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | |  | | |  | | | | |  | | | | | | | | |
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| Social Security #: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | |  | | |  | | | | |  | | | | | | | | |
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| Date of Birth: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | Age: | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | |  | | |  | | |  | | | | |  | | | | | | | | |
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| Was the patient adopted through DCFS? | | | | | | | | | | | | | | Yes | | | | | | | | | | | |  | | | No | | | | | | If yes, which County: | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |
| Is the patient under DCFS care? | | | | | | | | | | | | | | | Yes | | | | | | | | | | | |  | | | No | | | | | **X** | | If yes, which County: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |
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| **MEDI-CAL/ INSURANCE INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | | |  | |  | | |  | | | | | | | | | |
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| Medi-Cal #: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | Issue Date: | | | | | | | | | |  | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | |
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| Member ID: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | | |  | |  | | |  | | | | | | | | | |
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| Pre Authorization or Provider phone number: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | | |
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| Insurance Claims Address: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
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| **PARENT/CAREGIVER INFORMATRION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | |  | |  | | |  | | | | | | | | | |
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| Home Phone: | | |  | | | | | | | | | Cell Phone: | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | Work Phone: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
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| **REFERRING PARTY INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | |  | |  | | |  | | | | | | | | | |
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| Agency Name: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
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| Phone Number: | | | | |  | | | | | | | | | | | | | | | | | | Fax: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | |  | | | | | | | | |
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| **REASON FOR REFERRAL:** | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | |  | | | | |  |  | |
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| Verbal confirmation of exposure to alcohol prenatally? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | |  | | | | | No | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Documented confirmation of exposure to alcohol prenatally? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | |  | | | | | No | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Any history of drug or alcohol abuse by biological mother?  If yes, please explain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | |  | | | | | No | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Does the patient have any behavioral concerns? If yes, please explain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | |  | | | | No | | | | |  | | | |
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| Additional Information: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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**If available please fax or bring in the following documents to the appointment**

* Birth Records
* Medical Records
* Affidavits
* School IEP
* Regional Center Assessments
* PT/OT assessments
* Mental Health Assessments
* Speech/Language Assessments

**FAX COMPLETED REFERRAL TO 323.226.4403**

FASD Contact Yesenia Enciso 323.409.5086

yenciso@dhs.lacounty.gov

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| **OFFICE USE ONLY** | | | | | | | | | | | |
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| Date Rec’d: |  |  | **Comments** |  | | | | | |  | |
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| Rec’s By: |  |  |  |  | | | | | |  | |
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