**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**

|  |
| --- |
| **CLIENT INFORMATION** |
|  |  |  |  |  |  |  |  |  |
| Patient Name: |  |  |  |  |
|  |  |  |  |  |
| Previous Name (AKA): |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Social Security #: |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Date of Birth: |  |  Age: |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| 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: |  |  |
|  |  |  |  |  |  |  |  |  |
| **MEDI-CAL/ INSURANCE INFORMATION**  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Medi-Cal #: |  |  Issue Date: |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Insurance: |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Member ID: |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Pre Authorization or Provider phone number: |  |  |  |
|  |  |  |  |  |  |
| Insurance Claims Address: |  |  |
|  |  |  |
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| **PARENT/CAREGIVER INFORMATRION** |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Name: |  |  Relationship: |  |
|  |  |  |  |
| Address: |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |  |  |
| Home Phone: |  | Cell Phone: |  | Work Phone: |  |
|  |  |  |  |  |  |  |  |  |
| **REFERRING PARTY INFORMATION** |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Name: |  | Relationship: |  |
|  |  |  |  |  |  |  |  |  |
| Agency Name: |  |  |
|  |  |  |  |  |  |  |  |  |
| Address: |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Phone Number: |  | Fax: |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **REASON FOR REFERRAL:** |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Verbal confirmation of exposure to alcohol prenatally?  | Yes |  | No |  |  |
|  |  |  |  |  |  |
| Documented confirmation of exposure to alcohol prenatally? | Yes |  | No |  |  |
|  |  |  |  |  |  |
| 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** |
|  |  |  |  |  |  |  |  |  |
| Date Rec’d: |  |  | **Comments** |  |  |
|  |  |  |  |  |  |
| Rec’s By: |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |