Dear Sir or Madam,

Thank you very much for your request for an appointment to be seen in the Fetal Alcohol Spectrum Disorder (FASD) Clinic.

Our goal is to evaluate individuals of all ages at risk for FASD and to provide them appropriate referrals for their care. Clinics are held on Fridays. We are able to see two patients per clinic.

The next step for you is to complete the attached New Patient Information Form.

This form will help you and us to prepare for your clinic visit. It must be completed and returned to us before we can schedule your appointment. We realize you may not have all of the information requested on this form. Please do the best you can. Completing the section on maternal use of alcohol (page 8) is especially important. A patient must have a confirmed prenatal alcohol exposure to be seen in our clinic.

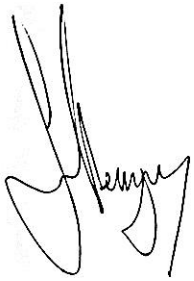
Please attach a close-up facial photograph of the patient with no smile.

Mail the completed New Patient Information Form and the photograph to:

Susan Astley Hemingway, Ph.D.
University of Washington
CHDD, FAS DPN
Box 357920
Seattle, WA 98195-7920

If you have any questions, please contact us at (206) 598-9666 or email us at fasdpn@uw.edu

Sincerely,



Susan Astley Hemingway, Ph.D.

Director, FAS DPN

New Patient Information Form FAS Clinic

Office Use: Date received ___/___/___ Deadline ___/___/___ ASAP ____ Response Let. ___/___/___ Photo ___ Screen Code _____
G _____ F _____ B _____ A _____ M _____: 1 2 3 4

Patient Identification

Patient's Social Security Number *(optional)* _____ ❑ Female ❑ Male Race _____

Patient's Name _____ Birth date _____Age _____
First *Middle* *Last*

Patient's Address _____

City _____ County _____ State _____ zip _____

Phone: Home ( ) _____ cell ( ) _____ email _____

Caregiver Identification

Name of patient's primary caregiver(s) _____

Relationship to patient: ❑ birth, ❑ adoptive, ❑ foster parent, ❑ other (specify _____)

Caregiver's Address _____

City _____ County _____ State _____ zip _____

Phone: Home ( ) _____ cell ( ) _____ email _____

Person Completing the Form

Name of person completing this form _____ Date _____

Relationship to patient: ❑ birth, ❑ adoptive, ❑ foster parent, ❑ caseworker, ❑ medical provider, ❑ _____

Referred by (person/organization who told you about the clinic) _____

Phone: work ( ) _____ cell ( ) _____ email _____

Who Should Correspondence be Sent To?

Name _____

Relationship to patient: ❑ birth, ❑ adoptive, ❑ foster parent, ❑ other (specify _____)

Address _____

City _____ County _____ State _____ zip _____

Phone: ( ) _____ cell ( ) _____ email _____

Legal Guardian (REQUIRED Information)

Name of patient's legal guardian _____

Phone: work ( ) _____ cell ( ) _____ email _____

Guardian's address

City _____ County _____ State _____ zip _____

Guardian's relationship to patient: ❑ family, ❑ caseworker, ❑ other (specify:_____)

Please complete this form to the best of your ability. We realize you will not have the answers to all questions. All information requested in this form is important in allowing us to provide you with the most accurate diagnosis and most appropriate referrals for care. Thank you for taking the time to complete it.

Reasons for Evaluation What are the patient's primary problems? Please be specific.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What do you hope to gain from the evaluation?

_____

_____

_____

_____

_____

_____

_____

_____

Growth

Birth Measures

1. Birth weight: lbs / oz _____ or gms _____

   Birth length: inches _____ or cm _____

   Birth head circumference: inches _____ or cm _____

   Gestational age *(length of pregnancy)*: weeks _____ or months _____

Please provide additional height, weight and head measures if available*

2. Date _____ Weight: lbs _____ or kg _____

   Age _____ Height: inches _____ or cm _____

   Head Circumference: inches _____ or cm _____

3. Date _____ Weight: lbs _____ or kg _____

   Age _____ Height: inches _____ or cm _____

   Head Circumference: inches _____ or cm _____

4. Date _____ Weight: lbs _____ or kg _____

   Age _____ Height: inches _____ or cm _____

   Head Circumference: inches _____ or cm _____

5. Date _____ Weight: lbs _____ or kg _____

   Age _____ Height: inches _____ or cm _____

   Head Circumference: inches _____ or cm _____

Birth Parents' Heights: Birth Mother: inches _____ or cm _____

Birth Father: inches _____ or cm _____

* This information may be available from the patient's physician or school nurse. If growth charts are available and can be photocopied and attached to this form, you need not fill out this section.

Physical Appearance and Health

1. **Photographs of the patient's face are very helpful to us.** The best photos are ones where the face fills the photo and the patient is not smiling. Pictures between ages 1 and 12 years are best.

   - Are such photographs available? ____ yes ____ no
   - Are one or two included with this form? ____ yes ____ no
   - Can others be brought to the clinic? ____ yes ____ no

Please staple photo(s) here:

Photo may be bigger than this space

2. **Was the patient born with (or later discovered to have) any birth defects (things like cleft lip, congenital heart defects, club foot, etc.)?** ____ yes ____ no _____ unknown

   If yes, please describe: _____

   _____

3. **Has this patient ever had:**

	yes	no	unknown		yes	no	unknown
Allergies	_____	_____	_____	Chronic illness of the heart	_____	_____	_____
Multiple ear infections	_____	_____	_____	Chronic illness of the kidneys	_____	_____	_____
Chronic sinusitis	_____	_____	_____	Chronic illness of the joints/limbs	_____	_____	_____
Chronic hearing loss	_____	_____	_____	Chronic illness of the stomach/ bowels	_____	_____	_____
Visual problems	_____	_____	_____				

4. **Has this patient ever had:**

   A. Operations (since birth) ____ yes ____ no ____ unknown

Describe Operation	Surgeon's Name	Patient's Age
_____	_____	_____
_____	_____	_____

   B. Any other hospitalizations ____ yes ____ no ____ unknown

Reason for Hospitalization	Hospital/Doctor	Patient's Age
_____	_____	_____
_____	_____	_____

   C. Physical abuse ____ yes ____ no ____ unknown Age(s): _____

   Was this evaluated by a physician? ____ yes ____ no ____ unknown

   D. Sexual abuse ____ yes ____ no ____ unknown Age(s): _____

   Was this evaluated by a physician? ____ yes ____ no ____ unknown

Neurological Issues

1. Has this patient ever had:

A. Seizures

____ yes ____ no ____ suspected ____ unknown

Type: _____

Age when seizure(s) started: _____

Name(s) of medication(s) given? _____

B. Loss of specific motor skills such as standing, walking, running, etc.

____ yes ____ no ____ unknown

If yes, please describe _____

C. Bed wetting or soiling after 8 years of age.

____ yes ____ no ____ unknown ___ not 8 years old yet

2. Has this patient ever had a head injury leading to unconsciousness or evaluation by a doctor?

____ yes ____ no ____ unknown

If yes, please describe _____

3. Has the patient ever had a CT scan or MRI scan of the brain

____ yes ____ no ____ unknown

If yes, was it described to be abnormal? ____ yes ____ no ____ unknown

Attention Deficit and Hyperactivity

1. Has the patient ever been evaluated for attention deficit/hyperactivity disorder (ADD / ADHD)

____ yes ____ no ____ unknown

If yes:

When was the evaluation done? Age: _____ Date: _____

Was the patient diagnosed with ADD or ADHD? ____ yes ____ no ____ unknown

Was the patient ever treated for ADD or ADHD? ____ yes ____ no ____ unknown

What medications have been tried?

Drug	Dose	Ages	Response

Mental Health Issues

1. Has the patient ever been evaluated by a psychiatrist, psychologist, or mental health counselor?

____ yes ____ no ____ unknown

If yes, please list each psychiatrist, psychologist and/or counselor.

A. Type of professional: _____

Reason for assessment: _____

Type of therapy (i.e., behavioral, individual counseling, group counseling, family counseling, medicine): _____

_____

Age at the time of therapy: _____ Did the therapy help? ____ yes ____ no ____ unknown

If yes, how did it help? _____

_____

_____

B. Type of professional: _____

Reason for assessment: _____

Type of therapy (i.e., behavioral, individual counseling, group counseling, family counseling, medicine): _____

_____

Age at the time of therapy: _____ Did the therapy help? ____ yes ____ no ____ unknown

If yes, how did it help?_____

_____

_____

2. Has the patient ever been evaluated for mood problems (depression, anxiety, etc.) or phobia?

____ yes ____ no ____ unknown

If yes:

When was the evaluation(s) done? Age(s): _____ Date(s): _____

3. What medications have ever been tried and how well did they work?

Drug	Dose	Response	Currently Using?

School Issues

1. List ALL schools the patient has attended and the grades of attendance:

School	City	Grades Attended	Received Special Education, Resource Room, Tutoring, etc. yes	no	unknown

2. What learning problems does the patient have?

3. What behavioral problems does the patient have?

Alcohol Exposure

Please fill in this information as completely as possible.

A confirmed history of alcohol use during this pregnancy is required for an appointment.

Alcohol use by the birth mother

- **Before pregnancy**: average number of drinks per drinking occasion: _____
  maximum number of drinks per occasion: _____
  average number of drinking days per week: _____
  Type(s) of alcohol: ___wine, ___beer, ___ liquor, ___ unknown, ___ other (specify) _____

- **During pregnancy:** average number of drinks per drinking occasion: _____
  maximum number of drinks per occasion: _____
  average number of drinking days per week: _____
  Type(s) of alcohol: ___wine, ___beer, ___ liquor, ___ unknown, ___ other (specify) _____

Which trimester(s) did the mother drink alcohol? ____ 1st ____2nd ____3rd ___unknown

	No	Yes	Unknown
Was the birth mother ever reported to have a problem with alcohol?	____	____	_____
Was the birth mother ever diagnosed with alcoholism?	____	____	_____
Did the birth mother ever receive treatment for alcohol addiction?	____	____	_____

If the above information is unknown, please provide any information that may help describe the mother's level of alcohol use DURING THIS PREGNANCY, not before or after this pregnancy.

_____

_____

_____

What is the source(s) of this information on alcohol use? _____

_____

Did the birth mother use any of the following substances during pregnancy?

Yes	No	Unknown	Type	Please List Specific Substance(s)	Month(s) of Pregnancy
___	___	___	Drugs	_____	_____
___	___	___	Tobacco	_____	_____
___	___	___	Medications	_____	_____
___	___	___	X-rays	_____	_____

Information about the Patient's Biological Parents

Birth mother's name_____ Birth date _____
First *Middle* *Last*

Mother's Race ❑ White ❑ Black ❑ American Indian ❑ Alaskan Native ❑ Hispanic
❑ Asian ❑ unknown ❑ other (specify) _____

Education level attained (last year of school completed) _____ Age at birth of patient ____

Does she have a history of learning problems? _____

Birth mother's Address _____
Street *City* *State* *Zip*

When was the last contact with the birth mother? _____

Birth father's name_____ Birth date _____
First *Middle* *Last*

Father's Race ❑ White ❑ Black ❑ American Indian ❑ Alaskan Native ❑ Hispanic
❑ Asian ❑ unknown ❑ other (specify) _____

Education level attained (last year of school completed) _____ Age at birth of patient _____

Does he have a history of learning problems? _____

When was the last contact with the birth father? _____

Medical History of the Biological Family

Has anyone in this patient's biological family ever had any of these conditions? *Check all that apply*.

	Birth Mother	Birth Father	Mother's Family	Father's Family	Siblings of patient
Alcoholism	_____	_____	_____	_____	_____
Birth Defects	_____	_____	_____	_____	_____
Stillbirths	_____	_____	_____	_____	_____
Miscarriages	_____	_____	_____	_____	_____
Mental retardation	_____	_____	_____	_____	_____
Other developmental disabilities	_____	_____	_____	_____	_____
Learning disorders	_____	_____	_____	_____	_____
Attention deficit	_____	_____	_____	_____	_____
Hyperactivity	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____
Neurological disease	_____	_____	_____	_____	_____
Child abuse	_____	_____	_____	_____	_____
Sexual abuse	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____
Suicide	_____	_____	_____	_____	_____
Mental illness	_____	_____	_____	_____	_____
Vision problems	_____	_____	_____	_____	_____
Hearing problems	_____	_____	_____	_____	_____
Chronic illnesses	_____	_____	_____	_____	_____
Tourette syndrome	_____	_____	_____	_____	_____
Delinquency	_____	_____	_____	_____	_____
Any specific genetic condition	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

Pregnancies of Birth Mother

1. Please list **all** of the birth mother's pregnancies including miscarriages, abortions, in the order of their occurrence:

Year	Length of Pregnancy	First name of child if applicable	Live born Child yes	Live born Child no	Normally Developed yes	Normally Developed no	If not normal, please explain *Include FAS / FAE diagnosis, if known*
_____	________	_________________	___	___	___	___	___________________________
_____	________	_________________	___	___	___	___	___________________________
_____	________	_________________	___	___	___	___	___________________________
_____	________	_________________	___	___	___	___	___________________________
_____	________	_________________	___	___	___	___	___________________________
_____	________	_________________	___	___	___	___	___________________________
_____	________	_________________	___	___	___	___	___________________________
_____	________	_________________	___	___	___	___	___________________________
_____	________	_________________	___	___	___	___	___________________________
_____	________	_________________	___	___	___	___	___________________________

Office Use:	Total Parity	Total Gravity	Patient Parity	Patient Gravity	FASD diagnoses

Pregnancy, Labor, and Delivery of this Patient

1. **Did the birth mother experience any difficulties during pregnancy?** __ Yes ___ No ___ Unk.

   If yes, please describe: ____

2. **Did the birth mother receive prenatal care?** ___ Yes ___ No ___ Unknown
3. **Were there complications during the labor or delivery?** ___ Yes ___ No ___ Unknown

   If yes, please explain:____

4. **Was the delivery:** _______ Natural ________ By C-section _______ Unknown
5. **Where was patient born?** Hospital Name ______________________________

   City ______________________ State ____________

6. **APGAR scores**: (at 1 minute _________) (at 5 minutes _________) (at 10 minutes _________)
7. **How many days did the infant stay in the birth hospital?** ____________________
8. **Did the patient have any of the following problems while still in the birth hospital?**

	Yes	No	Unknown		Yes	No	Unknown
Feeding problems	____	____	____	Infections	_____	_____	_____
Apnea / breathing difficulties	____	____	____	Jaundice	_____	_____	_____
Supplemental oxygen required	____	____	____	Convulsions	_____	_____	_____

List of ALL Professionals Currently Involved in Patient's Care

Primary Care Physician:

Name: _____ Phone: _____

Clinic/Hospital Name:_____ City: _____

Other Professionals Providing Care (other doctors, therapists, psychiatrists, mental health counselors, school psychologists)

Name: _____ Phone: _____

Specialty: _____

Clinic/Hospital Name:_____ City: _____

Name: _____ Phone: _____

Specialty: _____

Clinic/Hospital Name:_____ City: _____

Name: _____ Phone: _____

Specialty: _____

Clinic/Hospital Name:_____ City: _____

Name: _____ Phone: _____

Specialty: _____

Clinic/Hospital Name:_____ City: _____

Name: _____ Phone: _____

Specialty: _____

Clinic/Hospital Name:_____ City: _____

Name: _____ Phone: _____

Specialty: _____

Clinic/Hospital Name:_____ City: _____

Placements

1. List all of the placements the patient has had from birth through today.

Type of placement (i.e., foster, adoptive, etc.)	Duration of placement		Age of patient when placement started
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____

Office Use:	Total	First	Last

A. How long has the patient been in your care? _____

Next Step

When we receive your completed New Patient Information Form, we will review it and send you a letter within 2 weeks informing you of the status of your appointment request.