



Arkansas Department of Human Services
Division of Children and Family Services
FASD Screening Referral Form

Date:	Child's Name:	D.O.B:
County of Service:	Child's Client ID:	Case #:

Please check all that applies regarding placement and custody status:

<input type="checkbox"/> Foster Care	<input type="checkbox"/> TPR	<input type="checkbox"/> Pre-adoptive Placement	<input type="checkbox"/> Adopted
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Current School Location/Day Care/Residential Treatment facility, Address, & Phone Number:

Foster Parent(s)/Relative Placement/Adoptive Parent(s)/ Name, Address, & Phone Number:

Biological Mother's Name, Address, & Phone Number:

Primary Care Physician Name, Address, & Phone Number:

<p>Has a Comprehensive Health Assessment been completed?</p> <p><input type="checkbox"/> Yes (please provide copy with referral sheet).</p> <p><input type="checkbox"/> No (please provide all other assessments and/or evaluations).</p>	<p>Do you have a copy of the birth records?</p> <p><input type="checkbox"/> Yes (please provide copy with referral sheet).</p> <p><input type="checkbox"/> No (please provide name, address of Birth hospital and copy of latest court order).</p>
<p>Do you have personal knowledge or record indicating the child was exposed to alcohol in utero?</p> <p><input type="checkbox"/> Yes (please provide records with referral sheet)</p> <p><input type="checkbox"/> No (If TPR has taken place, please provide as much contact information on mom or relatives in space below)</p> <p>Additional information: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Does the child have any diagnosis?</p> <p><input type="checkbox"/> Yes (please list: _____)</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> No</p> <p>Additional information: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>

Please send referral sheet and additional requested documents to FASD Program Specialist: Robyn Manees:
P.O Box 1437, Slot S565, Little Rock, AR 72203-1437 Fax: 501-683-1469 Office: 501-683-4088.