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:
☐ Foster Care  ☐ TPR  ☐ Pre-adoptive Placement  ☐ Adopted

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:

Has a Comprehensive Health Assessment been completed?
☐ Yes (please provide copy with referral sheet).
☐ No (please provide all other assessments and/or evaluations).

____________________________________________________

Do you have a copy of the birth records?
☐ Yes (please provide copy with referral sheet).
☐ No (please provide name, address of Birth hospital and copy of latest court order).

____________________________________________________

Do you have personal knowledge or record indicating the child was exposed to alcohol in utero?
☐ Yes (please provide records with referral sheet)
☐ No (If TPR has taken place, please provide as much contact information on mom or relatives in space below)

Additional information: ____________________________________________________________

____________________________________________________

Does the child have any diagnosis?
☐ Yes (please list:____________________)

Additional information: ____________________________________________________________

____________________________________________________

Please send referral sheet and additional requested documents to FASD Program Specialist: Paula Mainard, FSW
P.O Box 1437, Slot SS69, Little Rock, AR  72203-1437 Fax: 501-683-1664 Office: 501-396-6471
Email: paula.mainard@dhs.arkansas.gov

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