The International Adoption Clinic
Of
Kennedy Krieger Institute and Johns Hopkins Children's Center

CLIENT INFORMATION

Today's Date: ______________________________

Name(s) of individual(s) requesting evaluation: ______________________________

Address: ______________________________

______________________________ ______________

City State Zip Code County

Home phone number: ______________________________

Work number(s): Name: ______________ Phone number: ______________

Fax number: ______________

Name: ______________ Phone number: ______________

Fax number: ______________

Fax number is requested so written report can be faxed before telephone conference.

❑ **Please check box if you want to be called before fax is sent.**

Referral source: ______________________________

Child's name: First: ______________ Last: ______________

Date of Birth: Month: ______________ Day: ______________ Year: ______

Gender of child: ☐ Male ☐ Female

Child's birth city and country: ______________________________

Name of orphanage (if applicable): ______________________________

Date child was placed in orphanage: ______________________________

What materials do you want evaluated?

❑ Videotape: Date(s) of videotape clip(s) and minutes of videotape clip(s) (**MANDATORY**)

Date(s) ____ ___ ________ Number of minute(s) ______________

- Please specify which child to evaluate if more than one child is shown on this tape.

❑ Medical Records

Client's relationship to the child: ☐ Worker/organization assisting with placement

☐ Prospective parent ☐ Other: ______________________

Other Comments: ______________________________

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Revised 01/24/03