

# FASD Diagnostic Team Data Collection Report

**Today's Date:** \_\_\_\_\_ **Client ID (if available):** \_\_\_\_\_ **Community Diagnostic Team:** \_\_\_\_\_

The information used in item I. is used only for your agency's tracking purposes and for reporting to the Birth Defects Registry.  
 The data reported to the Office of FAS **does not** include the client's first, middle or last name.

## I. TRACKING INFORMATION

**Client's Date of Birth:** \_\_\_\_\_ **Client's First Name:** \_\_\_\_\_ **Client's Middle Name:** \_\_\_\_\_ **Client's Last Name:** \_\_\_\_\_

The remaining Items II, III & IV are included with both your agency's report and the Office of FAS report. Items II and IV are also reported to the Birth Defects Registry.

## II. CLIENT DEMOGRAPHICS

Client's Gender: \_\_\_ Male \_\_\_ Female

Client's Race: \_\_\_ White \_\_\_ Black \_\_\_ Native Alaska \_\_\_ Indian American \_\_\_ Asian \_\_\_ Other Pacific Islander \_\_\_ Native Hawaiian or \_\_\_ Other

Is this client Hispanic or Latino? \_\_\_ Yes \_\_\_ No

What community does this client live in? \_\_\_\_\_

## III. CLIENT REFERRAL & BACKGROUND INFORMATION

Has the child had out of home placements? If so, how many \_\_\_\_\_ # \_\_\_\_\_ unknown

Who is this client's current primary caregiver?

<b>Both Biological Parents</b>	<b>Biological Mother Only</b>	<b>Biological Father Only</b>	<b>Adoptive Parents/Legal Guardian</b>	<b>Foster Parent(s)</b>	<b>Social Service Agency</b>	<b>Self</b>	<b>Other(specify)</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Who has legal custody of this client?

<b>Both Biological Parents</b>	<b>Biological Mother Only</b>	<b>Biological Father Only</b>	<b>Adoptive Parents/Legal Guardian</b>	<b>OCS Custody</b>	<b>Tribal Organization</b>	<b>Self</b>	<b>Other(specify)</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Where does this client currently live?

<b>Biological/Adoptive Parents or Legal Guardian</b>	<b>Other Family Placement</b>	<b>Foster Home</b>	<b>Residential Treatment</b>	<b>Juvenile Justice Facility</b>	<b>Receiving Home</b>	<b>Runaway Shelter</b>	<b>Other(specify)</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Who referred this client for FASD assessment?

<b>Parent(s) or Foster Parents</b>	<b>Medical Provider</b>	<b>Mental Health Provider</b>	<b>Probation Office</b>	<b>OCS</b>	<b>School</b>	<b>Self</b>	<b>Other(specify)</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Has this client's biological mother given birth to other children? \_\_\_ Yes \_\_\_ No \_\_\_ Unknown. If Yes, how many? \_\_\_\_\_ #

Have any of these siblings been diagnosed with FASD? \_\_\_ Yes \_\_\_ No \_\_\_ Unknown

If Yes, how many of these diagnosed siblings are older than the client? \_\_\_\_\_ # And how many are younger? \_\_\_\_\_ #

## IV. FAS DIAGNOSTIC INFORMATION

Date of Initial Referral \_\_\_\_\_ Date of First Appointment \_\_\_\_\_ Date that Diagnosis was Completed \_\_\_\_\_ 4-digit Diagnostic Code \_\_\_\_\_

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