Dear Parent or Guardian,

Thank you for your interest in our Fetal Alcohol Spectrum Disorders Clinic. We look forward to meeting you and your child. Enclosed with this letter is the documentation that is required for an evaluation. Once received, we will schedule an appointment.

Please check the following boxes and return the supporting documents to our clinic. Some of the information can be obtained by using the Release of Information forms included in this packet.

A. **Confirmed Prenatal Alcohol Exposure** (2 of the following are required)
   - ○ Birth records/ neonatal discharge summary with prenatal history
   - ○ Foster care records indicating maternal alcohol use in pregnancy
   - ○ Adoption records indicating maternal alcohol use in pregnancy
   - ○ Documentation of maternal alcohol use (e.g. DUI; documentation of substance use treatment)

B. **Growth** (2 of the following are required)
   - ○ Birth records/ neonatal discharge summary with birth weight and length
   - ○ Growth chart since infancy with height and weight documented

C. **Structural Brain Abnormalities** (1 of the following are required)
   - ○ Growth chart since infancy with head circumference documented
   - ○ Report of MRI brain documenting structural abnormalities

D. **Cognitive or Neurobehavioral Deficits** (1 of the following are required)
   - ○ Copy of most recent MET Evaluation and IEP (within last 2 years)
   - ○ Copy of most recent neuropsychological evaluation (within last 2 years)
   - ○ Copy of most recent psychiatric evaluation (within last 2 years)

E. **FASD Intake Form Signed Release of Information** (This will be sent to the patient's family on the referral is received)
   - ○ Completed forms

Please mail to:
Specialty Clinic
850 W. Baraga Ave. Ste 31
Marquette, MI 49855

As soon as we have received the completed paperwork, we will add the child to our waitlist for an evaluation. Please understand that we are a small sub-specialty clinic, and **our wait time for an appointment is approximately 9-12 months**. To ensure that an assessment is scheduled promptly, we request all paperwork be returned to the office within 30 days. If you do not hear from us within 2 weeks of returning the paperwork, please get in touch with our clinic at 906-449-4880 to ensure we received everything. **Patients with incomplete paperwork will not be scheduled.**

Sincerely,

UP Health System Marquette Specialty Clinic

C.S. MOTT CHILDREN'S HOSPITAL
MICHIGAN MEDICINE

Fetal Alcohol Spectrum Disorders Clinic
Parent Questionnaire

Child's Name:	Date of birth:	Gender:
Your name:	Your relationship to child:	
Telephone (home):	Telephone (work):	
Telephone (cell):	Email address:	
Address:		
Name of Child's Doctor:		
Telephone:	Fax:	
Address:		

Caseworker (if applicable): _____ Telephone: _____

Who suggested you come for this evaluation?

CHIEF COMPLAINT: *What is your greatest concern about your child for which you would like help?*

HISTORY OF PRESENTING ILLNESS: *When did the problem begin? What have you tried to make it better?*

What do you hope to gain from the evaluation?

TRAUMA HISTORY: *Has your child experienced trauma in his/her life? Check yes/no for each.*

Has your child experienced…	Yes	No
Has your child ever been in or seen a serious accident where someone could have been, or was severely injured or died?		
Has your child ever been in a serious natural disaster where someone could have, or was severely injured or died?		
Has your child ever experienced the severe illness or injury of someone close to him/her?		
Has your child ever experienced the death of someone close to him/her?		
Has your child ever undergone any serious medical procedures or had a life threatening illness? Or been treated by a paramedic, seen in an emergency room, or hospitalized overnight for a medical procedure?		
Has your child ever been separated from you or another person who your child depends on for love or security for more than a few days OR under very stressful circumstances? (Foster care, immigration, war, major illness, or hospitalization)		
Has someone close to your child ever attempted suicide or harmed him or herself?		
Has someone ever physically assaulted your child, like hitting, pushing, choking, shaking, biting, or burning? Or punished your child and caused physical injury or bruises. Or attacked your child with a gun, knife, or other weapon? (This could be done by someone in the family or by someone not in your child's family).		
Has someone ever directly threatened your child with serious physical harm?		
Has someone ever mugged or tried to steal from your child? Or has your child been present when a family member, other caregiver, or friend was mugged?		
Has anyone ever kidnapped your child? (including a parent or relative) Or has anyone ever kidnapped someone close to your child?		
Has your child ever been attacked by a dog or other animal?		
Has your child ever seen, heard, or heard about people in your family physically fighting, hitting, slapping, kicking, or pushing each other? Or shooting with a gun or stabbing, or using any other kind of dangerous weapon?		
Has your child ever seen or heard people in your family threaten to seriously harm each other?		
Has your child ever known or seen that a family member was arrested, jailed, imprisoned, or taken away (like by police, soldiers, or other authorities?)		
Has your child ever seen or heard people outside your family fighting, hitting, pushing, or attacking each other? Or seen or heard about violence such as beatings, shootings, or muggings that occurred in settings that are important to your child, such as school, your neighborhood, or the neighborhood of someone important to your child?		
Has your child ever been directly exposed to war, armed conflict, or terrorism?		
Has your child ever seen or heard acts of war or terrorism on the television or radio?		
Has someone ever made your child see or do something sexual (like touching in a sexual way, exposing self or masturbating in front of the child, engaging in sexual intercourse)?		
Has your child ever been present when someone was being forced to engage in any sort of sexual activity?		
Has your child ever repeatedly ben told s/he was no good, yelled at in a scary way, or had someone threaten to abandon, leave or send him/her away?		
Has your child ever gone through a period when s/he lacked appropriate care (like not having enough to eat or drink, lacking shelter, being left alone when s/he was too young to care for herself/himself, or being left with a caregiver who was abusing drugs)?		
Have there been other stressful things that have happened to your child?		

TESI SCORE:

PLACEMENT HISTORY:

How old was your child when you received them into your home? _____

Describe your relationship to your child:
□ Biological parent □ Legal guardian □ Foster parent □ Adoptive parent □Other: _____

Has your child ever been in foster care? □ NO □ YES: # of placements: _____

Caregiver/Placement	Age of Child/duration of placement	Reason for placement change
1.		
2.		
3.		
4.		
5.		

PREVIOUS EVALUTIONS: *Please indicate any evaluations your child has received. Check all that apply.*

	Results of evaluation if known
□ Early On/Early Intervention	
□ Speech/Language Therapy	
□ Physical Therapy	
□ Occupational Therapy	
□ Behavioral Therapy/Counseling	
□ IQ or Psychological Testing	
□ Genetics	

PSYCHIATRIC HISTORY:

Has your child ever been evaluated by a psychiatrist, psychologist, or mental health counselor?
□ NO
□ YES, *please indicate the psychiatric diagnoses given at the time.*

Has your child ever been **hospitalized** for psychiatric reasons?
□ NO
□ YES, *please indicate the reason for the hospitalization, location and child's age at the time.*

Has your child ever received **medication** for psychiatric reasons?
□ NO
□ YES, *please indicate the medication, reason/diagnosis and child's age at the time.*

EDUCATION HISTORY:

Child's School:	Grade:

Does your child have an IEP: □ NO □ YES; Qualification for IEP:_____

Services on IEP:

	Frequency of Services
□ ECDD Classroom	
□ Speech/Language Therapy	
□ Physical Therapy	
□ Occupational Therapy	
□ Social Work / Behavioral support	
□ Resource Room	
□ OTHER	

PAST MEDICAL HISTORY:

Pregnancy History *(if known)***:**

Prenatal care began in trimester: □ 1 □ 2 □ 3 □ No prenatal care

This was pregnancy # _____ Total pregnancies _____ Living children _____

Pregnancy was complicated by the following: *Check all that apply.*

□ Diabetes
□ High Blood Pressure
□ Maternal depression
□ Intimate partner violence
□ Tobacco use: _____ cigarettes/day
□ Substance use: _____
□ Preterm labor: _____ weeks
□ Other: _____
□ NONE

PRENATAL ALCOHOL USE: *It is critical that we have reliable information about the mother's use of alcohol during pregnancy; information about alcohol use prior to pregnancy is also helpful, if known. Although anecdotal information is helpful, the patient might not receive an alcohol-related diagnosis if alcohol history is unconfirmed. Provide what you can; casework records are often a source for this information, and we urge parents to find verifiable information if at all possible.*

	Beer How much? How often?	**Wine** How much? How often?	**Liquor** How much? How often?
BEFORE pregnancy			
DURING pregnancy □ 1st Trimester			
□ 2nd Trimester			
□ 3rd Trimester			

Has the mother had any of the following alcohol related risk factors before or during pregnancy:

	Yes	No	Unknown
≥ 6 drinks / week for ≥ 2 weeks during pregnancy			
≥ 3 drinks per occasion on ≥ 2 occasions during pregnancy			
Documentation of alcohol-related social or legal problems in proximity to (before or during) the index pregnancy (e.g. history of DUI or treatment of an alcohol related disorder)			
Documentation of intoxication during pregnancy by blood, breath, or urine alcohol content testing			
Positive testing with an established alcohol-exposure biomarker during pregnancy or at birth			
Increased prenatal risk associated with drinking during pregnancy identified on a screening test (e.g. TACER; AUDIT)			

Was the mother ever in treatment for **alcohol abuse**?
□ NO □ YES, when: _____ where: _____

Was the mother ever in treatment for **substance abuse**?
□ NO □ YES, when: _____ where: _____
Medications taken during pregnancy: *Check all that apply.*
□ Prenatal vitamins □ Folic acid □ Other: _____

BIRTH HISTORY *(if known):*

Birth Hospital: _____ City, State: _____

Name at birth (if different from current name): _____

Gestational Age:
Birth weight: _____ Birth length: _____ Head circumference: _____
Delivery: □ Vaginal □ C-section

Neonatal history was notable for the following: *Describe any complications during/after birth.*

GROWTH HISTORY: *Has your child ever demonstrated poor growth/weight gain?*

□ No problems with growth or weight gain (growth/weight gain have been normal)
□ History of **POOR WEIGHT GAIN** (weight < 10%) When: _____
□ History of **POOR GROWTH** (height < 10%) When: _____

CURRENT MEDICAL PROBLEMS:

Surgeries:

Hospitalizations:

Allergies:

Current Medications:

REVIEW OF SYSTEMS: *Does your child have any of the following? Check all that apply.*

System	Description
□ Breathing problems	
□ Heart/circulation problems	
□ Neurological problems (e.g. seizures, headaches)	
□ Feeding/growth problems	
□ Problems with blood (e.g. anemia, leukemia)	
□ Chronic infections	
□ Problems with kidneys	
□ Musculoskeletal problems	
□ Vision problems	
□ Hearing problems	
□ Endocrine problems	
□ Urological problems	
□ Sleep problems	
□ Elimination problems	
□ OTHER	

BIOLOGICAL FAMILY HISTORY: *Family history is notable for the following. Check all that apply.*

Family History of	Person(s) Affected
□ ADHD	
□ Autism	
□ Developmental delay	
□ Learning disability/repeated grade in school	
□ Depression	
□ Other mental illness: _____	
□ Alcohol abuse	
□ Substance abuse	
□ Incarceration	
□ OTHER: _____	

SOCIAL HISTORY: *Who lives at home? Check all that apply.*

Relationship	Age	Job/Occupation
□		
□		
□		
□		
□		
□		
□		
□		
□		
□		

Stressors: *Please indicate if your child has experienced any of the following. Check all that apply.*

□ Domestic violence
□ Child physical abuse
□ Sexual abuse
□ Neglect
□ CPS involvement
□ Foster care
□ Institutionalization
□ Financial concerns
□ OTHER: _____

OTHER QUESTIONS OR CONCERNS: