



International Adoption Clinic

747 52nd Street, Oakland, CA 94618 - 510-428-3010 - Fax: 510-450-5878

Pre-Adoption Client Information

Adoptive Parent(s):

DOB: _____

DOB: _____

SSN: _____

SSN: _____

Address: _____

City: _____ State: _____ County: _____ Zip Code: _____

Telephone numbers:

Name: _____

Home () _____ Cell () _____

Work () _____ Fax () _____

Name: _____

Home () _____ Cell () _____

Work () _____ Fax () _____

E-mail address(es): _____

Referral Source (adoption agency / organization): _____

How did you learn about the International Adoption Clinic at Children's Hospital & Research Center Oakland?

Internet site _____

Doctor referral _____

Friend referral _____

Adoption agency _____

Other _____

Child's name: _____

Child's DOB: _____

Child's birth country: _____ City: _____

Province/region: _____

Name of orphanage(s), if applicable:

If you are a prospective parent, how certain are you about adopting this child prior to evaluation?

- Certain
- Fairly Certain
- Uncertain

What materials do you want evaluated?

Medical Records

Name/organization of the translator _____

Photographs

Number of photos _____ Approximate dates _____

Videos

Date _____ Length _____

It is important to indicate the length and number of video segments on the tape you provide. If the video is longer than 15 minutes, we may need additional time to provide you with the verbal and written reports. Depending on the length of the videotape, there may be an additional fee for consideration.

Other documents (Please specify)

If multiple children are recorded on the video, please indicate this below. Identify each child by some distinctive feature, (e.g. clothing). A separate intake form should be filled out for each child.

Please list any additional information about the child, which may not be included in the provided materials.

Please list any specific questions you may have about this child.

PLEASE REMEMBER:

Materials cannot be returned. They will be kept at Children's Hospital & Research Center Oakland Medical Records department.

Initial and date all materials.

Please send:

- This completed form
- The Consent for Pre-Adoption Evaluation
- A check made out to "Children's Hospital & Research Center Oakland International Adoption Clinic"

Mail to:

Children's Hospital & Research Center Oakland
International Adoption Clinic
Attn: Nancy Curtis, MD
747 52nd Street
Oakland, CA 94609

Please call our office if you choose to pay by credit card or if you have any questions/concerns. You can reach us at 510-428-3010.