

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: _____

Additional Contact Information: Name: _____ Cell phone number: _____

Email address: _____

Name: _____ Cell phone number: _____

Email address: _____

Email is requested so written report can be sent before telephone conference.

If you prefer to receive written report via fax, please list fax number: _____

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: _____

