

VCU International Adoption Medical Clinic

Client Information Form

Today's Date:

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

Address:

Home Phone Number:

Work number(s): 1) Name:

Phone Number:

FAX:

Email:

2) Name:

Phone Number:

FAX:

Email:

Please check box if you want to be called before fax is sent (i.e. common fax)

Referral Source:

Child's Name:
First Name Last Name

Date of Birth:
Month Day Year

Gender of Child: Male Female

Child's Birth City and Country:

Name of Orphanage (if applicable):

Date Placed in Orphanage:

What materials do you want evaluated? Videotape: Date of videotape clip(s) Number of
Minute(s) (Please specify which child to evaluate if there is more than one child on the videotape)

Medical Record(s) Pictures

Client's relationship to the child: worker /organization assisting Prospective Parent Other

Other Comments: