CHILDREN'S HOSPITAL
& RESEARCH CENTER OAKLAND

**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 specifty)

_____

_____

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.