

# Parent-Child Assistance Program

12/15/09

FADU, Box 359112, University of Washington School of Medicine (206) 543-7155

## COMMUNITY REFERRAL SCREENING QUESTIONNAIRE (CRSQ)

**\*\* CHILD WITH FASD \*\***

IRB recruitment script read      Date of Referral (mo/day/yr): \_\_\_\_\_

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**REFERRAL SOURCE**      Name/Position: \_\_\_\_\_ Phone: \_\_\_\_\_  
Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
(include zip code)

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**CLIENT INFORMATION**      Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
(include zip code)

How to contact:

**Demographics:** Client DOB (mo/day/yr): \_\_\_\_\_  
Age: \_\_\_\_\_ Race/ethnicity: \_\_\_\_\_ Number of children: \_\_\_\_\_  
Marital status: \_\_\_\_\_ Highest grade completed in school: \_\_\_\_\_

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### ELIGIBILITY FOR ENROLLMENT *[Client must meet all 3 conditions below to be enrolled in PCAP]*

#### 1. PREVIOUSLY DELIVERED A CHILD WITH A FETAL ALCOHOL SPECTRUM DISORDER (FASD)?

**FASD diagnosis made by a:**

Physician     Psychologist     Neuropsychologist     Other \_\_\_\_\_

Who? \_\_\_\_\_ Where? \_\_\_\_\_

**Diagnosis:**     FAS (partial)     PFAS     FAE (partial)     PFAE  
 ARND     Static encephalopathy, alcohol exposed

Birthdate of this child: \_\_\_\_\_ Current age: \_\_\_\_\_ Age at diagnosis: \_\_\_\_\_

Name: \_\_\_\_\_ Gender: \_\_\_\_\_

**Does she have other children diagnosed with a FASD?** ..... Yes ..... No

**• CONDITION 1:**

CHILD DIAGNOSED WITH FASD BY A PHYSICIAN OR QUALIFIED PROFESSIONAL? ..... NO ..... YES  
ineligible

**2. SELF-REPORT OF CURRENT ALCOHOL ABUSE**

Self-report of binge drinking ( $\geq 4$  drinks per occasion)..... Yes ..... No  
Self-report of daily drinking (of any amount)..... Yes ..... No  
Self-report of drinking between meals ..... Yes ..... No  
Has medical or social problems due to current alcohol abuse..... Yes ..... No  
If yes, describe: \_\_\_\_\_

• **CONDITION 2:**  
**CURRENT ONGOING ALCOHOL ABUSE?**..... NO ..... YES  
**ineligible**

**3. IS BIOLOGICALLY CAPABLE OF BEARING A CHILD?**

Has she had a tubal ligation? ..... Yes ..... No  
Where? \_\_\_\_\_ When? \_\_\_\_\_

Is she in child-bearing years? (approximately 17–45 years)..... Yes ..... No

• **CONDITION 3:**  
**ELIGIBLE IF TUBAL LIGATION IS NO AND IN CHILDBEARING YEARS IS YES**..... NO ..... YES  
**ineligible**

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**OTHER NOTES/CONTACTS MADE:** *(include reason if referral is not eligible for enrollment, or eligible but not enrolled)*