Adoption Health Services of Western Pennsylvania

Name (s):_____ Date: _____

Address: _____ Agency: _____
_____ Placement: _____
Home Study: _____
Country: _____

Phone Numbers: _____
Parent Name: _____ Parent Name: _____
Home: _____ Home: _____
Work: _____ Work: _____
Cell :_____ Cell: _____
Fax: _____ Fax: _____
E-mail: _____ E-mail: _____

How did you hear about us? _____

How early and late may we call you?_____

What time zone are you in?_____

Best time and location to reach you? We will do our best around patient scheduling to reach you when it is most convenient for you.

_____

Please list any specific concerns which you have:_____
_____
_____

FOR OFFICE USE ONLY:

____"ADOPTION 101" CONSULT __VIDEO
____ SPECIAL NEEDS CONSULT __PRE TRAVEL CONSULT/BLIND REFERRAL
____ WRITTEN INFO./PHOTOS __EXPEDITED REVIEW

DATE RECEIVED:_____ DATE PAID:_____
CALLED TO DISCUSS:_____ RECEIPT:_____
SIGNED RELEASE RECEIVED:__

ARTICLES SENT:
_GENERAL PACKET __BLIND REFERRAL PACKET_CHINA TRAVEL PACKET ___OTHER