

Client Information

Name _____

Address _____ Apt. or Suite No. _____

City _____ State _____ Zip Code _____

Home Phone () _____ Cell () _____ Work () _____

E-mail Address _____

When service is available, would you like to receive E-mail... (check all that apply)

Event Reminders Newsletter

For prenatal diagnosis, provide due date _____

*Name of your child with Down syndrome _____

Date of Birth _____ Male Female

Relationship to person with Down syndrome (check all that apply)

Please Select
From The
Following:

- | | |
|---|---|
| <input type="checkbox"/> Person with Down syndrome | <input type="checkbox"/> Educator |
| <input type="checkbox"/> Parent and/or Primary Care Giver | <input type="checkbox"/> Business Sponsor |
| <input type="checkbox"/> Grandparent | <input type="checkbox"/> Agency Affiliate |
| <input type="checkbox"/> Sibling | <input type="checkbox"/> Donor |
| <input type="checkbox"/> Healthcare Professional | <input type="checkbox"/> Other _____ |

What is the primary language spoken at home?

English Spanish Other _____

Would you like personal contact from a member of our Family Faculty? Yes No

Referred by: _____

Office Use:

Date added to mailing list: _____

Date current information mailed: _____

Processed by: _____

Please fax or mail information to: **DSACC**
4277 W. Richert Ave., Suite 102, Fresno, Ca 93722
T (559) 228-0411 F (559) 228-0414
E-mail: info@dsacc.org

*If parents prefer not to provide personal information, kindly forward only date of birth and gender of baby