



## Phone Call Intake Form

*Please complete this form each time you have contact with a new family. Write any pertinent notes on the back of this page for future reference.*

Name: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Affected loved ones name(s): \_\_\_\_\_

Phone: (cell) \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Preferred method of contact: (email/phone/Facebook) \_\_\_\_\_

Date you were given name \_\_\_\_\_ By whom? (NFXF, Clinic, FB outreach/other) \_\_\_\_\_

First contact made by: Phone \_\_\_\_\_ Email \_\_\_\_\_ In Person \_\_\_\_\_ Facebook \_\_\_\_\_ Other \_\_\_\_\_

Did you make follow up contact? Date: \_\_\_\_\_ By: Phone \_\_\_\_\_ Email \_\_\_\_\_ Other \_\_\_\_\_

Was a referral made to (if not referred by):

The NFXF? \_\_\_\_\_ The local FXCRC clinic? \_\_\_\_\_

Was permission to share information (if not referred by) given for:

The NFXF: \_\_\_\_\_ The local FXCRC clinic? \_\_\_\_\_

Name, age, gender and diagnosis of family member(s) with FXS or FXTAS:

Name, age, gender of unaffected family member(s)

Has this information been added to your local CSN Group database? \_\_\_\_\_ Date \_\_\_\_\_