MEDICAL REPORT FOR ADOPTIVE PARENT

Patient's name _____ DOB _____ Age _____

Address _____

Date of examination _____

Length of time known to physician _____

Is the patient free of HIV/AIDS, Tuberculosis, and Hepatitis B, or any other communicable disease? _____ Date of PPD (tuberculosis test) result _____
If not, please explain treatment and prognosis. _____

_____

Is the patient free from any disease or condition that would affect his or her parenting? _____
If not, please explain treatment and prognosis. _____

_____

Please document any other medical history, such as surgery, traumas, or hospitalizations:

_____

_____

Has the patient ever had a chemical dependency? _____ If so, please explain. _____

_____

Has the patient ever had a mental health or psychiatric diagnosis? _____ If so, please explain. _____

Is the patient physically capable of having children? _____ If not, please document diagnosis, treatment given, and any further treatment recommended: _____

_____

Please document any other physical limitations: _____

_____

Please describe the findings of your examination of the patient. _____

_____

Has your examination revealed any threat to the patient's general health and life expectancy? _____ If so, please explain. _____

_____

Has your examination revealed any threat to the patient's ability to parent a child? _____
If so, please explain. _____

_____

What are your impressions of the patient's physical and emotional qualifications for parenthood? _____

_____

Printed Name of Physician	Signature of Physician
Address	Date
City State Zip	Physician's Specialty
Telephone	

Please mail this report to:

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