Florida Adoption Center LLC

Love Makes a Difference!

MEDICAL REPORT FORM

As part of your Home Study Process a current medical report/physical is required for all prospective adoptive parents. Please make an appointment with your family physician or OB/GYN to have this form completed. If you have recently had a physical and it is within the past 60 days, your physician may use the results of that exam to complete this form, and you will not need another physical.

If you are prescribed any psychotropic medication or under the care of a psychiatrist or mental health professional, we require a letter from him/her on letterhead stating diagnosis, medication prescribed and cooperation with treatment.

Name of Applicant: _____ DOB: _____

Date of examination: _____

I, hereby give my authorization for my Physician to release the following information to the Agency Named above:

Signature of Applicant: _____ Date: _____

Results of Examination: CURRENT PHYSICAL EXAMINATION (Within 60 Days of This Form's Completion Date)

Hair Color_____Eye Color_____Height_____Weight_____Blood Pressure_____

Vision_____Hearing_____Speech Impairments_____Temperature_____

Pulse_____Eyes_____Ears_____Extremities_____Heart_____

Abdomen_____Nose & Throat_____Lungs_____PAP Smear_____

Urinalysis_____Date of UA_____Date of Blood Work_____(Attach a copy of blood work results)

After this physical Exam, were there any recommendations for medical care made to the patient? If so, please state the recommendations.

1. What is the general physical condition of the patient?

2. Is the patient free from any communicable diseases? If No Explain.

3. Is the patient expected to have an average life expectancy? If No Explain.

4. Does the patient have a current problem with drug use/abuse [ ] Yes [ ] No. If "Yes" please give details.

5. Has the patient had a past problem with drug use/abuse? [ ] Yes [ ] No. If "Yes" please give details.

6. Has this patient had a past problem with or alcohol abuse/dependency? [ ] Yes [ ] No. If "Yes" please explain giving extent/nature, treatment received, dates and current status.

7. Is the patient physically and emotionally able to assume responsibility for an adoptive child? [ ] Yes [ ] No. If "No", please explain.

8. Has the patient had outpatient or inpatient psychiatric care? If so, please explain, giving diagnosis/nature, dates and current status.

9. Please indicate any other pertinent medical information **including any medications** this patient is currently prescribed. Please include name of medication and dosage.

10. If the examiner has known the patient personally or as a family physician, his or her comments concerning the patient will be appreciated.

I hereby certify that I have examined the above patient. In my professional opinion, this patient **is / is not (circle one)** physically and mentally capable of undertaking the care of an adoptive child.

_____ _____
Physician's Printed Name Physician's License #

_____
Physicians Signature

Facility Name: _____

Address: _____

City: _____ State: _____

Phone: _____ Fax: _____

Office Stamp: _____

Date: _____