

Christian Family Services, Inc.

MEDICAL REPORT - 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? _____ 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: Christian Family Services, Inc.
PO Box 36426
Rock Hill, SC 29732

Contact Info: (803) 328-2229