

MEDICAL REPORT – Other Children

Patient's name _____ DOB _____ Age _____

Address _____

Date of examination _____

Length of time known to physician _____

Has the patient had any diseases such as: allergies; diabetes; tuberculosis; cancer; heart disease; epilepsy; ulcers; or sickle cell anemia? _____

Please explain treatment and prognosis _____

Other medical history, such as surgery, traumas, or hospitalizations _____

Has the patient ever had a chemical dependency? _____ If so, for how long? _____

Please explain _____

Mental health history, such as emotional problems, depression, or nervous disorders

Please describe any physical limitations such as glasses, hearing impairment, or dialysis

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?

Date of Examination _____

Printed name of Physician

Signature of Physician

Address

Physician's specialty

City

State

Zip

Telephone

Please mail this report to:

Sharon Cole, LMSW, Executive Director
Christian Family Services, Inc.
2166-A Gold Hill Road
Fort Mill, South Carolina 29708
803-548-6030