

PHYSICIAN'S EXAMINATION OF ADOPTION APPLICANT/PETITIONER

PATIENT'S NAME

PATIENT'S SIGNATURE

DATE

I hereby authorize Dr. _____, to release the medical information contained on this form to the _____ (insert name of licensed adoption agency or CDSS Adoptions Branch District Office) for the purpose of investigating the adoptive placement of a child.

Por este medio autorizo al Dr. _____ para que comparta la información médica contenida en este formulario con _____ (escriba el nombre de la oficina/agencia de adopciones certificada o de la Oficina de Distrito correspondiente a la Oficina Central de Adopciones del Departamento de Servicios Sociales de California) para el propósito de investigar la colocación del niño en adopción.

I. MEDICAL HISTORY

Check if condition is present and provide comment

- | | | |
|-----------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Cancer | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Impaired Hearing (Extent) | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Impaired Sight (Extent) | <input type="checkbox"/> Allergies | <input type="checkbox"/> Neurosis |
| <input type="checkbox"/> Any Surgical Operations | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Speech Defects (Describe) | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Orthopedic Defects | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Chemical Dependence | <input type="checkbox"/> Other Medical Condition | |
| <input type="checkbox"/> History of Hereditary Disease or Abnormality | | |

Comments: _____

II. PHYSICAL EXAMINATION

Height _____ Weight _____

_____ Eyes	_____ TB Test (Date & Finding)
_____ Ear, Nose, Throat	_____ Cholesterol Reading
_____ Heart	_____ Blood Pressure Reading
_____ Lungs	_____ Urinalysis (Date/Finding)
_____ Pelvic	_____ Genito-Urinary
_____ Abdominal	

III. ABILITY TO HAVE OWN CHILDHas the patient been under treatment for infertility/sterility? ☐ YES ☐ NOIf infertility/sterility exists, has the medical basis been determined? ☐ YES ☐ NO

If YES, give results of studies: _____

With proper treatment, would impregnation be possible? ☐ YES ☐ NO

What medication(s) is patient currently taking?

What medication(s) has been prescribed in the recent past?

Is there any organic or functional disorder that would affect the patient's life expectancy or ability to function as a parent? ☐ YES ☐ NO

If YES, please elaborate:

How long have you known the patient? _____

From a medical viewpoint, would you recommend this patient as an adoptive parent?..... ☐ YES ☐ NO

If NO, please elaborate:

Based on your knowledge and observations of the patient, how would you assess his/her adjustment to this adoptive placement?

☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ QUESTIONABLE ☐ DON'T KNOW

Please use this space for any additional comments: _____

[illegible]

DATE EXAMINED	SIGNATURE OF DOCTOR
ADDRESS OF DOCTOR	
TELEPHONE NUMBER	TYPED NAME OF DOCTOR

Please mail directly to:

OPTIONAL HIV TEST AND DISCLOSURE AUTHORIZATION

The HIV test and authorization to disclose the results of the test are optional and intended only for patients who wish to submit to, or have undergone, a blood test for antibodies to the probative causative agent of acquired immune deficiency syndrome (AIDS) and choose to have their health care provider disclose the results of the test in accordance with Health and Safety Code Section 199.21 (g).

I hereby authorize Dr. _____ to release results of an HIV test to (1) _____ (insert name of licensed adoption agency or CDSS Adoptions Branch District Office) for the purpose of investigating the adoptive placement of a child and (2) the _____ County Superior Court for the purpose of the adoption proceeding.

PATIENT'S SIGNATURE

DATE

PRUEBA OPCIONAL DEL VIH* Y AUTORIZACION OPCIONAL PARA COMPARTIR INFORMACION

La prueba del VIH y la autorización para compartir los resultados de la prueba son opcionales y solamente son pertinentes a los pacientes que deseen someterse, o que ya se hayan sometido, a un análisis de sangre para detectar anticuerpos del agente que se ha probado es la causa del SIDA**, y estas personas eligen que su proveedor de cuidado de la salud comparta los resultados de la prueba, en conformidad con la sección 199.21 (g) del Código de Salud y Seguridad.

Por este medio autorizo al Dr. _____ para que comparta los resultados de la prueba del VIH con (1) _____ (escriba el nombre de la oficina/agencia de adopciones certificada o de la Oficina de Distrito correspondiente a la Oficina Central de Adopciones del Departamento de Servicios Sociales de California) para el propósito de investigar la colocación del niño en adopción y (2) la Corte Superior del Condado de _____ para fines del trámite de adopción.

FIRMA DEL PACIENTE

FECHA

HIV TEST RESULTS

(DATE OF TEST AND FINDING)

SIGNATURE OF DOCTOR

DATE

ADDRESS OF DOCTOR

TYPED NAME OF DOCTOR

TELEPHONE NUMBER

SEND RESULTS TO:

*virus de inmunodeficiencia humana
**síndrome de inmunodeficiencia adquirida