

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

- Mental Illness, Impaired Hearing (Extent), Impaired Sight (Extent), Any Surgical Operations, Speech Defects (Describe), Orthopedic Defects, Chemical Dependence, History of Hereditary Disease or Abnormality, Cancer, Hypertension, Allergies, Diabetes, Arthritis, Tuberculosis, Other Medical Condition, Ulcers, Heart Disease, Neurosis, Epilepsy, Venereal Disease, Depression

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 CHILD

Has the patient been under treatment for infertility/sterility? _____ YES NO

If 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

IV. GENERAL HEALTH AND PHYSICAL CONDITION

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: _____

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
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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
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HIV TEST RESULTS (DATE OF TEST AND FINDING)

SIGNATURE OF DOCTOR	DATE
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ADDRESS OF DOCTOR

TYPED NAME OF DOCTOR	TELEPHONE NUMBER
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SEND RESULTS TO:

*virus de inmunodeficiencia humana
**síndrome de inmunodeficiencia adquirida