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

_____________________________ Ear, Nose, Throat

_____________________________ Heart

_____________________________ Lungs

_____________________________ Pelvic

_____________________________ Abdominal

_____________________________ TB Test (Date & Finding)

_____________________________ Cholesterol Reading

_____________________________ Blood Pressure Reading

_____________________________ Urinalysis (Date/Finding)

_____________________________ Genito-Urinary

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

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