LDSS 0571 (Rev. 5/2004)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICAL REPORT OF PROSPECTIVE ADOPTIVE PARENT

AGENCY:	TELEPHONE NUMBER:	DATE ISSUED:
NAME OF PROSPECTIVE ADOPTIVE PARENT:	ADDRESS OF PROSPECTIVE ADOPTIVE PARENT:	

I hereby request and authorize my physician to release the following information to the agency named above.

SIGNATURE OF ADOPTIVE APPLICANT:
X

TO PHYSICIAN:
The above-named parent has applied to adopt a child. A medical report and your interpretation of it are needed by the adoptive staff and the agency's medical advisors. Our serious responsibility is to select adoptive parents whose general health and emotional stability would enable them to give the child a satisfying life.

Section A. MEDICAL HISTORY

Past History of Illness – Diagnosis and Date

Surgery – Specify and Indicate Date:

Accidents:

Hospital or Sanitarium Care – Other than above:

Section B. PHYSICAL EXAMINATION

Temperature:	Pulse:	Weight:	Height:	Blood Pressure:

Eyes:	Vision:	Hearing:

Lungs:	Date of X-ray:	Results of X-ray:	Teeth and Gums:

Nose and Throat:	Neck:	Heart:

Lymph Gland System:	Pelvis:
Abdomen:	Extremities:
Nervous System:	
Endocrine:	Skin:
Rectal Examination:	

Section C. LABORATORY TESTS			
Serology:	Hemoglobin:	Blood Smear:	Date Tests Given:
Urinalysis – Specific gravity:	Urinalysis – Sugar:	Urinalysis – Albumin:	PAP:

Section D. GENERAL

Impression of general health and vitality level:

Has patient usual life expectancy: ☐ YES ☐ NO

If No, state nature of problem

Is patient on any regular medication or was any recommendation for medical care made to patient? ☐ YES ☐ NO

If Yes, state nature of problem

How long have you known the patient professionally:

From your experience with the patient, are there any additional comments:

Physician's Signature: **X**	Telephone Number:	Date Signed:
Physician's Address:		

RETURN COMPLETED REPORT TO:

Agency:

RETURN ENVELOPE ENCLOSED