

(TO BE COMPLETED BY PHYSICIAN)

State of Maryland – Resource Development and Placement
PATIENT MEDICAL INFORMATION – CHILD (In Applicants Home)

TO THE EXAMINING PHYSICIAN

The applicant below is a child living in a home considering the placement of a child. The Department of Social Services needs information on his/her physical and mental health, and the extent and significance of health any conditions that may relate to his/her presence in the home.

CHILDS FULL NAME

DATE OF BIRTH

HOW LONG PHYSICIAN HAS KNOWN APPLICANT

I. PHYSICAL EXAMINATION

1. HEIGHT	2. WEIGHT	3. TEMPERATURE	4. PULSE	5. BLOOD PRESSURE	6. RESPIRATION RATE	7. VISION	8. HEARING
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9. LUNGS	10. HEART
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11. ALLERGIES

12. NERVOUS SYSYTEM	13. ENDOCRINE
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14. CURRENT PRESCRIBED MEDICATIONS:

II. LABORATORY TESTS (optional, list tests and results)

Chest X-Ray

III. Are immunizations up to date?

IV. GENERAL HEALTH: (attach additional pages as needed)

1. DOES THE PATIENT HAVE THE USUAL LIFE EXPECTANCY?

2. DOES THE PATIENT HAVE A CHRONIC OR ACUTE DISEASE?

3. DOES THE PATIENT HAVE A CHRONIC DISEASE, A BEHAVIORAL CONDITION OR ANY DISABILITY THAT MAY AFFECT THE WELL-BEING OF A FOSTER OR ADOPTIVE CHILD IN THE HOME?

4. WAS ANY RECOMMENDATION FOR MEDICAL CARE MADE TO THE PATIENT? IF YES, EXPLAIN.

5. HAS THE PATIENT BEEN TREATED OR HOSPITALIZED FOR ANY OF THE FOLLOWING: (explain)

- ANXIETY
- DEPRESSION
- SUICIDE ATTEMPTS
- ALCOHOLISM
- DRUG/SUBSTANCE ABUSE
- BI-POLAR DISORDER
- PSYCHOSIS
- OTHER (explain)

V. Additional Comments:

PHYSICIANS SIGNATURE	DATE OF EXAM	RETURN COMPLETED FORM TO:
PHYSICIANS NAME (Print or Type)	TELEPHONE	
Address (Include City, State, Zip Code)		

State of Maryland – Resource Development and Placement
APPLICANT MEDICAL INFORMATION - CHILD

1. FULL NAME

2. BIRTHDATE

3. BRIEFLY DESCRIBE AND GIVE APPROXIMATE DATES FOR THE FOLLOWING:

a. MAJOR ILLNESSES:

b. HOSPITALIZATIONS:

c. SURGERY:

d. ACCIDENTS:

e. PSYCHIATRIC/MENTAL HEALTH TREATMENT:

f. ALCOHOL / DRUG TREATMENT:

4. FAMILY MEDICAL HISTORY - IS THERE A HISTORY OF:

	YES	NO		YES	NO		YES	NO
ALLERGIES.....	<input type="checkbox"/>	<input type="checkbox"/>	ALCOHOL / DRUG USE.....	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA.....	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES.....	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL ILLNESS / RETARDATION.....	<input type="checkbox"/>	<input type="checkbox"/>	OTHER (specify)		
HEART DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	HYPERTENSION.....	<input type="checkbox"/>	<input type="checkbox"/>			
CANCER.....	<input type="checkbox"/>	<input type="checkbox"/>	LUNG DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>			

5. DESCRIBE THE CHILD'S GENERAL HEALTH CONDITION & LIST ANY CURRENT MEDICATIONS:

6. IS THE CHILD CURRENTLY RECEIVING ANY TREATMENT, THERAPY OR REHABILITATION FOR ANY MEDICAL OR MENTAL HEALTH PROBLEMS? YES NO (If yes, please provide name, address and telephone number of provider)

7. DOES THE CHILD HAVE ANY PHYSICAL OR BEHAVIORAL DISABILITIES OR SPECIAL NEEDS? (if yes, please describe)

(TO BE COMPLETED BY PHYSICIAN)

State of Maryland – Resource Development and Placement
APPLICANT MEDICAL INFORMATION – ADULT

TO THE EXAMINING PHYSICIAN

The applicant below is considering the placement of a child in their home. The Department of Social Services needs information on his/her physical and mental health, and the extent and significance of any health condition that may affect their ability to parent a foster/adoptive child.

APPLICANTS FULL NAME	DATE OF BIRTH	HOW LONG PHYSICIAN HAS KNOWN APPLICANT
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I. PHYSICAL EXAMINATION

1. HEIGHT	2. WEIGHT	3. TEMPERATURE	4. PULSE	5. BLOOD PRESSURE	6. RESPIRATION RATE	7. VISION	8. HEARING
9. LUNGS				10. HEART			
11. ALLERGIES							
12. NERVOUS SYSYEM				13. ENDOCRINE			

14. LIST CURRENT PRESCRIBED MEDICATIONS:

II. LABORATORY TESTS

	Date	Results
Tuberculin Test		
Chest X-Ray		

III. REASONS FOR CHILDLESSNESS, IF APPLICABLE (include prognosis, if known)

IV. GENERAL HEALTH: (attach additional pages as needed)

1. DOES THE PATIENT HAVE THE USUAL LIFE EXPECTANCY?

2. DOES THE PATIENT HAVE A CONTAGIOUS OR INFECTUOUS DISEASE?

3. DOES THE PATIENT HAVE A CHRONIC DISEASE OR EMOTIONAL CONDITION THAT WILL AFFECT THE PARENTING OF A FOSTER OR ADOPTIVE CHILD?

4. WAS ANY RECOMMENDATION FOR MEDICAL OR MENTAL HEALTH CARE MADE TO THE PATIENT? IF YES, EXPLAIN

5. HAS THE PATIENT BEEN TREATED OR HOSPITALIZED FOR ANY OF THE FOLLOWING: (explain)

- | | |
|---|---|
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> DRUG/SUBSTANCE ABUSE |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> BI-POLAR DISORDER |
| <input type="checkbox"/> SUICIDE ATTEMPTS | <input type="checkbox"/> PSYCHOSIS |
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> OTHER (explain) |

V. Would you recommend this patient as a Resource Parent? (If examiner knows patient personally as the family physician, any comment would be welcome)

PHYSICIANS SIGNATURE	DATE OF EXAM	RETURN COMPLETED FORM TO:
PHYSICIANS NAME (Print or Type)	TELEPHONE	
Address (Include City, State, Zip Code)		

State of Maryland – Resource Development and Placement
APPLICANT MEDICAL INFORMATION – ADULT

1. FULL NAME	2. BIRTHDATE
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3. BRIEFLY DESCRIBE AND GIVE APPROXIMATE DATES FOR THE FOLLOWING:

a. MAJOR ILLNESSES:

b. HOSPITALIZATIONS:

c. SURGERY:

d. ACCIDENTS:

e. PREGNANCIES:

f. PSYCHIATRIC/MENTAL HEALTH TREATMENT:

g. ALCOHOL / DRUG TREATMENT:

4. FAMILY MEDICAL HISTORY - IS THERE A HISTORY OF:

	YES	NO		YES	NO		YES	NO
ALLERGIES.....	<input type="checkbox"/>	<input type="checkbox"/>	ALCOHOL / DRUG USE.....	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA.....	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES.....	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL ILLNESS / RETARDATION.....	<input type="checkbox"/>	<input type="checkbox"/>	OTHER (specify).....	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	HYPERTENSION.....	<input type="checkbox"/>	<input type="checkbox"/>			
CANCER.....	<input type="checkbox"/>	<input type="checkbox"/>	LUNG DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>			

5. DESCRIBE YOUR GENERAL HEALTH CONDITION: *(please list any medications you are taking)*

6. ARE YOU CURRENTLY RECEIVING ANY TREATMENT, THERAPY OR REHABILITATION FOR MEDICAL OR EMOTIONAL PROBLEMS? YES NO *(If yes, provide nature of treatment & name, address and telephone of provider)*

7. DO YOU DRINK ALCOHOLIC BEVERAGES? YES NO *(if yes, how much and how often?)*

8. DO YOU SMOKE? YES NO

9. HAVE YOU EVER USED ILLEGAL CONTROLLED DANGEROUS SUBSTANCES? YES NO

10. HAVE YOU EVER UNDERGONE FERTILITY TESTING? YES NO