WASHTENAW COUNTY TRIAL COURT
ADOPTION UNIT

ADULT MEDICAL REPORT

Patient Name:	Date of Birth:
I authorize *(name of health care provider)* to release and exchange medical information to the Adoption staff at the Washtenaw County Juvenile Court – Family Division – Adoption Unit for the purpose of completing an adoption investigation. This information is not limited to but includes the release of information regarding HIV, ARC, and AIDS.	
Signature of Patient	Date:

To the Health Care Provider:
Prior to approval for adoption, the physical and mental health of household members must be assessed to determine the health of the child and the degree that the health or safety of the child and the quality of his/her care must not be adversely affected by the adoption. To assist in this matter, please complete this form based upon the information gathered during a recent exam with the above-named patient. If you wish to discuss the contents of this report, you may call the Adoption Specialist at (734) 222-6938. If there is no need to discuss the report, please return it to the patient.

Date of Exam:	How long have you known this patient?:	
Height:	Weight:	Blood Pressure:

Does the exam reveal evidence of past or present disease or physical limitation because of:			
	Yes	No	Explanation (date of onset, severity, duration, treatment, results, prognosis)
Skin or Lymph Glands	☐	☐	
Eyes, Ears, Nose, Throat	☐	☐	
Heart/Lungs	☐	☐	
Cancer	☐	☐	
Stomach/Abdomen	☐	☐	
Genital Urinary System	☐	☐	
Central Nervous System	☐	☐	
Venereal Disease	☐	☐	
Alcohol/Substance Abuse	☐	☐	
Chronic Ailments	☐	☐	
Other	☐	☐	

Laboratory Findings (if indicated by patient need risk):

	Date	Results
Tuberculin Skin Test		
VDRL		
Hepatitis B		
HIV		
Other		

Are you aware of any social, psychological, or medical reasons that could interfere with the patient's ability to parent a child?

☐ Yes ☐ No

Explanation, if necessary:

How would you describe this patient's general physical and mental health? (Check all that apply)

☐ Good health with no limitations for work with or around children.
☐ Health problem or concern noted but no limitations for work with or around children.
☐ Health problem or concern noted but has no bearing on shortened life expectancy.
☐ Health problem or concern noted that would affect the ability to care for a child.
☐ Health problem or concern noted that would lead to shortened life expectancy.
☐ Health problem or concern that indicated lifting restrictions.

Comments:

Health Care Provider Printed Name:		
Health Care Provider Signature:	Date:	
Address:		
City:	Zip:	Telephone: