

**Physicians Report**

(Form To Be Completed by Physician)

Exam Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Weight: \_\_\_\_\_

Height: \_\_\_\_\_

Does this patient have any medical or psychiatric problems that could affect their ability to be an adoptive parent? **Yes No**

Is this patient free of any communicable or infectious diseases? **Yes No**

Based on current medical information, does this patient have a normal life expectancy? **Yes No**

Doctors Name, MD \_\_\_\_\_

Doctors Signature \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_