MEDICAL REPORT FOR CAREGIVING AND ADOPTION

Medical report for caregiving and/or adoption

Doctor's name: _____

Medical Practice: _____

Address: _____

_____

_____

Name of applicant: _____

Address: _____

_____

Phone: _____

has applied to Oranga Tamariki—Ministry for Children to be assessed as a caregiver or an adoptive parent.

A separate medical report is required on each person wanting to adopt or to care for a tamaiti/child on behalf of the Chief Executive (each person in a joint application needs a separate medical report).

The purpose of this medical report is to identify whether the person is physically, mentally and emotionally fit to accept the responsibility and to cope with the demands of caring for a tamaiti/child. The information you provide in this report may be shared with the person this report is for.

If there are sections in this report that require further details, please attach the additional information as extra sheets and refer to this in the relevant section. If you would like to discuss any aspect of this application, please contact:

Name of social worker: _____ Phone: _____

Name of supervisor: _____ Phone: _____

Oranga Tamariki—Ministry for Children office: _____

Part A: Applicant to complete

Doctor: _____

Medical Practice: _____

Address: _____

_____

_____

I agree to the use, collection and disclosure of information about me, pursuant to the Privacy Act 1993. Oranga Tamariki—Ministry for Children will use the information for the purpose of assessing my suitability as an adoptive parent or caregiver and for further statutory obligations under the Oranga Tamariki Act 1989, Children's Act 2014, the Adoption Act 1955, the Adoption (Intercountry) Act 1997 and/or the Care of Children Act 2004.

I understand that the doctor may wish to see and examine me in order to complete the report.
(cross out statement below that does not apply)

a. as an adoptive applicant, I will be responsible for paying any fees for the completion of this report and any associated consultation, investigation or examination.

b. as a caregiving applicant, fees will be paid by Oranga Tamariki.

I understand that the information contained in this report may be made known to the court(s) hearing my application for an adoption order or a care order.

I understand that in the case of an intercountry adoption, this report will be sent to the adoption authorities in the country to which I am applying to adopt, as one of the supporting documents accompanying my adoption application.

I have read this form and authorise the doctor to complete this report and forward it directly (with an invoice in the case of a caregiver report) to:
(Fill in office address below)

Oranga Tamariki—Ministry for Children

Address: _____

_____

Attn: Social Worker: _____

Applicant Name: _____

Applicant's signature: _____

Date: _____

Part B: Doctor to complete

How long have you been this person's doctor? _____

What has been the consultation pattern over the past two years?

_____

_____

_____

Personal medical history

Does this person have any of the following conditions?
If **YES**, please comment on following page.

Hypertension or other cardiovascular disease	Yes ☐	No ☐
Respiratory disorders	Yes ☐	No ☐
Visual conditions or blindness	Yes ☐	No ☐
Reduced hearing or deafness	Yes ☐	No ☐
Head injury, fits or other neurological disease	Yes ☐	No ☐
Depression, anxiety state, stress-related disorder	Yes ☐	No ☐
Other mental health problems	Yes ☐	No ☐
Any form of arthritis or reduced mobility disease	Yes ☐	No ☐
Any condition causing persistent or extreme pain	Yes ☐	No ☐
Chronic renal disease	Yes ☐	No ☐
Diabetes, thyroid or other endocrine disorder	Yes ☐	No ☐
Gastrointestinal or liver disease	Yes ☐	No ☐
Disease related to the immune system	Yes ☐	No ☐
Blood disorder	Yes ☐	No ☐
Hepatitis or other viral infections or conditions	Yes ☐	No ☐
HIV/AIDS	Yes ☐	No ☐
Any form of cancer or suspected malignant disease	Yes ☐	No ☐
Restricted use of any limbs	Yes ☐	No ☐

Anything else of significance, please specify:

_____

Please comment on any of the above conditions and give details of treatment and prognosis and any medication being prescribed at present, including duration and side effects.

Please comment on the above conditions (and/or identify any other conditions the applicant has) which you consider may impact on their ability to provide short term or long term care for tamariki/children.

Have historical medical records been accessed to complete this report?

Yes ☐ No ☐

If the applicant is receiving any specialist treatment, please give details of the specialist/s and the reason/s for the treatment and whether it will impact their ability to provide care for tamariki/children.

Please comment on the applicants use of tobacco or alcohol, or 'recreational' illegal drugs (as applicable).

Family history

Is there a family history of any of the following?

Alcoholism or drug dependence	Yes ☐	No ☐
Mental health issues	Yes ☐	No ☐
Degenerative disease	Yes ☐	No ☐

Please provide any other medical history that may be hereditary that may impact on their ability to care for tamariki/children.

Fertility

Is the applicant undergoing any fertility treatment?

Yes ☐ No ☐

If **YES**, please detail reasons:

Relationship history

Are you aware of any difficulties in the applicant's marital or family relationships, including physical or emotional abuse?

Yes ☐ No ☐

If **YES**, please elaborate:

If the applicant already has tamariki/children, can you comment on any aspects of their parenting ability?

Evaluation of applicant

Do you consider the applicant to be in good physical health currently?

Yes ☐ No ☐

If **NO**, please elaborate:

Do you consider the applicant to have sound mental health currently?

Yes ☐ No ☐

If **NO**, please elaborate:

Is there any additional information not included in the above, which you consider pertinent to this report?

Have the contents of this report been shared with the applicant?

Yes ☐ No ☐

If **NO**, do you wish to comment?

Doctor's name: _____

Doctor's signature: _____

Date: _____

Thank you for taking the time to provide your medical report.