APPENDICE E

CatholicCare

FAC: OOHC PROGRAMS FORM: PROSPECTIVE FOSTER CARER MEDICAL REPORT

Form number: OOHC 036.2
Issued: January 2015
Contact: Team Leader
Ph. (02) 8700 3333

Surname: ______________________________

First Name(s): ______________________________

Address: ______________________________

Date of last Medical Examination: ______________________________

How long has he/she been your patient? ______________________________

What is his/her current state of physical health? ______________________________

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What is his/her current state of mental health? ______________________________

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Is he/she on any medication? If so please specify. ______________________________

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For what condition and for how long? ______________________________

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From what major illnesses has he/she suffered in the past? ______________________________

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Is there anything in his/her medical history which could affect him/her meeting the needs of a child with / without disabilities now or in the future? ______________________________

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Is there any reason why this person/couple is unable to have children of their own? ______________________________

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Name: ______________________ Signature: ______________________

Address: ______________________ Date: ______________________

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