



MEDICAL QUESTIONNAIRE ON PROSPECTIVE FOSTER CARER

Dear Doctor

Please complete this report for the person named below, who is applying to become a Foster Carer with the Marymead Child and family Centre.

The purpose of this report is to provide information to Marymead to assist in their determination of the applicant's general health and wellbeing. The report should consider the applicant's health as it is today and also provide consideration on how their care for a foster child on a long-term basis may be affected by their health and wellbeing.

Name of Applicant:

Gender:

DOB:

Address:

For how long has the applicant used your services as a GP?: _____

When did the applicant last have their health assessed by you?: _____

The applicant has been advised by Marymead that if they have not had their health assessed by you in the past twelve months, they will be required to do so for the purpose of this report.

1. PERSONAL HISTORY

Is there a history of the following illness? If 'yes', please provide relevant details in the space provided below the questions.

- | | | |
|------------------------------------------------|-----|----|
| a) Cardiovascular illnesses | Yes | No |
| b) Tuberculosis | Yes | No |
| c) Asthma | Yes | No |
| d) Bronchiectasis or chronic bronchitis | Yes | No |
| e) Emphysema | Yes | No |
| f) Other respiratory disorder | Yes | No |
| g) Any form of rheumatism or locomotor disease | Yes | No |

h) Nervous disorder, depression, anxiety state, or mental illness	Yes	No
i) Head injury, fits, or other neurological disease	Yes	No
k) Genito-urinary disease	Yes	No
l) Diabetes or thyroid disorder	Yes	No
m) Any form of blood-borne disease	Yes	No
n) Persistent indigestion, peptic ulcer, intestinal or liver disease	Yes	No
o) Malignant or suspected malignant disease	Yes	No
p) Previous operations or hospitalization records	Yes	No
q) Allergy	Yes	No
r) Other	Yes	No

If you answered 'yes' to any of the questions above please provide relevant details:

2. FAMILY HISTORY

Are you aware of the any of the following illness in the applicant's family? If 'yes':

a) Mental Illness	Yes	No
b) Epilepsy	Yes	No
c) Cardiovascular	Yes	No
d) Diabetes	Yes	No
e) Allergy	Yes	No
f) Kidney/Liver Disease	Yes	No
g) Degenerative Disease, eg: Muscular Dystrophy	Yes	No

If you answered 'yes' to any of the questions above please provide relevant details:

3. IS ANY FERTILITY TREATMENT CURRENTLY BEING UNDERTAKEN? Yes No

If you answered 'yes' to this question please provide relevant details:

4. CURRENT EXAMINATION FINDINGS:

- | | | |
|------------------------------------------------------------------------------------------------------------------------|-----|----|
| a) Is the applicant within a healthy weight range?: | Yes | No |
| b) Has the applicant normal use of limbs? | Yes | No |
| c) To the best of your awareness, does the applicant use any prescribed drugs, non-prescribed drugs, alcohol, tobacco? | Yes | No |
| d) Is the applicant currently receiving any medical treatment? | Yes | No |

Please provide any details you believe would be relevant to our assessment:

5. FURTHER INFORMATION

- | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| a) Has the applicant any medical condition that is likely to shorten life? | Yes | No |
| b) Are there any disabilities or illnesses that you consider would limit or adversely affect the applicant's ability to care for a child either now, or at any time in the foreseeable future? | Yes | No |
| c) Do you recommend the applicant as having suitable physical and mental health to be able to care for a child? | Yes | No |
| d) Is there any additional information not included in the above that you consider pertinent to this report? | Yes | No |
| e) Have the contents of this report been shared with the applicant? | Yes | No |
| f) Is there any further information that you believe would assist us in determining if the applicant's health would impact on their ability to care for a child? | Yes | No |

Please provide any details you believe would be relevant to our assessment:

Please attach any documentation that you believe may be helpful in assessing the applicant's appropriateness to undertake Foster Care work.

DOCTOR COMPLETING FORM:

Signature: _____ Date: ___ / ___ / ___

Name in block letters: _____ Qualifications: _____

Address: _____

Telephone: _____ Email (if practical): _____

For any further information please contact the Marymead Recruitment & Training staff member who sent you this form, as identified in the cover letter.

Thank you for taking the time to complete this report.

Please return the report in the reply paid envelope or send to:

**Recruitment and Training,
Foster Care Program
PO Box 4260
KINGSTON ACT 2604**