Siena Adoption Services

4141 North Henderson Rd

Plaza Suite 4

Arlington, VA 22203

Physician Report

(to be completed by physician)

Exam Date ___________________________________

Patient Name ___________________________________

Name of Adoptive Applicant whom patient lives with _____________________

Patient's relationship to adoptive applicant ______________________________

Address: ____

____

Phone:__________________________

Date of birth:_____________________

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 communicable diseases such as tuberculosis? ______________

Based on current medical information, does this patient have a normal life expectancy?

Yes ____ No ____

Is this report based on a current examination only or on a longer professional relationship?

____

If school aged child, do they have current immunizations? Yes _____ No _____

(If yes, please attach a copy of the immunizations record)

Doctor’s Name, MD ___________________________________

Doctor’s Signature ____________________________________

Address: ____

____

Phone:____

Please attach photocopy of MD license