Medical Information and Physician's Referral

(A separate medical form is needed for each adult member of the household)

I hereby give my consent to have a complete report of any diagnosis and medical information about me sent to *A Guardian Angel Adoptions, LLC* and agree to hold all parties blameless for any outcome of such medical disclosure.

Adoptive Parent Name: _____ Date:_____

Address: _____

Please Return to:

A Guardian Angel Adoptions, LLC
P.O. Box 95902
South Jordan, Utah 84095

Physician Name _____ Date_____

Phone _____

Physician Address _____

City _____ State_____ Zip_____

In order to make the best possible evaluation of this adoptive applicant, *A Guardian Angel Adoptions, LLC* would appreciate receiving the information indicated below concerning this applicant. Please use an additional sheet if necessary.

1-General Physical Condition: Please indicate general physical and mental condition, listing any past or present history illnesses, surgery, the cause, diagnosis, and prognosis:

2- Is this individual currently under treatment? Yes ( ) No ( ) If yes, describe the condition:

3- If yes to number two above, how long is this individual expected to be under treatment.

4- Is this individual currently taking medication, which could affect his/her ability to care for children? Yes ( ) No ( ) If yes, please describe:

5 - In your medical opinion is this patient psychically and emotionally able to assume the responsibility of parenthood? Yes ( ) No ( ) If no, please explain.

6- Describe this patients limitations that could impact the applicant's ability to parent.

7- Would you like the agency social worker to call you? Yes ( ) No ( )

Physician's Signature: _____ Date: _____