Siena Adoption Services

2776 S. Arlington Mill Dr. Suite #524
Arlington, VA 22206

(703) 477-0411

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