DEPARTMENT OF SOCIAL AND HEALTH SERVICES
CHILDREN'S ADMINISTRATION

申请人医疗报告书 - 保密文件
Applicant Medical Report - CONFIDENTIAL

DATE 日期

Section 1: Completed by Applicant and sent to Medical Provider
第 1 部分：由申请人填写并发送给医疗服务提供者

MEDICAL PROVIDER 医疗服务提供者	PHONE NUMBER (AREA CODE) 电话号码（区号）	RETURN TO CA WORKER 回函请寄至 CA 工作人员
ADDRESS 地址		
CITY 城市	STATE 州 / ZIP CODE 邮政编码	

NAME OF APPLICANT 申请人姓名	DATE OF BIRTH 出生日期

I hereby authorize my medical provider to release my medical history information including, but not limited to, information on the issues I have initialed below. This information is required as part of a home study for foster care and/or adoption. This release of information is valid for one year from date of my signature. **NOTE: Be sure to initial each line and sign.**

____ mental illness, ____ alcohol and drug concerns, ____ sexual and/or physical abuse, ____ domestic violence.

我特此授权我的医疗服务提供者披露本人病史资料，其中包括但并不局限于本人以姓名缩写标示的下列问题。要求提供这些情况，以便进行出于寄养看护和（或）领养目的之家庭情况考察。从本人签署之日起，此项情况披露的有效期为一年。**注意：确保在每一行的行首做标记并签名。**

____ 心理疾病，____ 酒精与药物滥用方面的问题，____ 性虐待和（或）人身虐待，____ 家庭暴力。

SIGNATURE OF APPLICANT 申请人签名   DATE 日期

Section 2: Completed by Medical Provider and sent to CA Worker Return Address above
第 2 部分：由医疗服务提供者填写并发送给上方的 CA 工作人员回寄地址

DATE FIRST SEEN BY PROVIDER 初次在服务提供者处就医的日期		DATE OF LAST PHYSICAL EXAMINATION 上一次体检的日期
DATE AND RESULTS OF LAST TB TEST 上一次 TB 检测结果和日期	DATE OF LAST TDAP 上一次 TDAP 的日期	DATE OF LAST INFLUENZA VACCINE 上一次注射流感疫苗的日期
SPECIALIST REFERRED TO 转介的专科医生为	ADDRESS OF SPECIALIST 专科医生的地址	
REASON FOR REFERRAL 转介原因		
SIGNIFICANT PAST MEDICAL HISTORY INCLUDING CHRONIC / FREQUENT MEDICAL ISSUES 以往病史（包括慢性病/频发病）		
CURRENT MEDICAL DIAGNOSIS 目前的医疗诊断		

CURRENT MEDICATIONS: PLEASE STATE THE PURPOSE OF THE MEDICATION, ANTICIPATED SIDE EFFECTS AND CONCERNS IF THE MEDICATION IS NOT TAKEN, AND HOW IT AFFECTS DAILY FUNCTIONING. 目前服用的药物：请陈明用药目的、预期的副作用，以及对不服用此药之后果的担忧，以及对日常生活功能的影响。	
PROGNOSIS 预后	
PLEASE DESCRIBE HOW ANY MEDICAL CONDITION AFFECTS THE CARE OF CHILDREN. 请描述病症对照看儿童有何影响。	
COMMENTS OR IMPRESSIONS 评论或想法	
MEDICAL PROVIDER’S SIGNATURE 医疗服务提供者签名	DATE 日期