FIRST HOME CARE –
HEALTH STATEMENT PERMANENT HOUSEHOLD MEMBER
FOSTER/ADOPTIVE FAMILY HOUSEHOLD

Name of Patient: _____ Date of Birth: _____

Address: _____

Note to Physician: **Please fill out each section.**

1. Please evaluate the patient's current health status:

_____

_____

2. Please evaluate the patient's current mental status:

☐ Stable at the time of this assessment

☐ Not stable, please explain: _____

_____

3. Patient being evaluated is assessed as Negative and free from Tuberculosis (TB) in a communicable form as a result of one of the following: (Please check one)

☐ PPD Test (negative) Date of Test: _____ Date of Reading: _____

☐ Chest X-Ray Date: _____

☐ Annual TB Screening completed in lieu of tests due to patient having no risk factors and presenting as communicably free from TB.

If patient being evaluated is positive for TB please explain: _____

_____

4. In your opinion, will the health of this patient negatively affect the care of foster children?

☐ No

☐ Yes Please explain: _____

_____

5. Comments/Recommendations: _____

Signed: _____ **Date of Evaluation:** _____
Physician/Designee

Printed Name: _____ Practice: _____
Physician/Designee

Telephone Number: _____ Address: _____

Agency Use Only: Foster/Adoptive Family: _____