FACS reference:<insert ChildStory contact reference number>
Name: <insert name>
Contact us: <insert number>
Date:

<insert name, press ENTER, position/title>
<insert address lines> separated by ENTER key

Medical check form

Dear <insert name>

<insert name of applicant> has applied to become a guardian and have nominated you as the doctor able to provide information about <his/her> health status. A signed medical check consent form is attached.

The purpose of this medical check is to identify any medical issues that may impact on <insert applicant name> capacity to provide day-to-day care for a child or young person until they are 18 years of age.

Please complete the attached form and return it to <insert CSC and address>.

A caseworker may contact you to clarify the information provided or request additional information. The information you provide will be treated in the strictest confidence in accordance with the Privacy and Personal Information Protection Act 1998.

Under the Government Information (Public Access) Act 2009, <insert applicant's name> may apply to view information about them held by Family and Community Services. This includes the outcome of the medical check.

If you wish to discuss this request or require further information, please contact <insert name and position> on < insert phone number> during business hours.

Yours sincerely
<insert name>
<insert title>

Medical check form for guardians

Applicant

Name	Date of Birth

Address

Nominated Doctor

Details of doctor completing questionnaire

Name

Address

Phone Number	Provider Number

Email

Consent

I consent to the release of medical information held by my doctor nominated above. ☐

Signature	Date

Medical check form for guardians

Doctor

How long have you been the applicant's doctor?

Please comment on the general health and medical history of the applicant, with reference to both physical and psychological aspects. *(please provide full details)*

Details

Are there any current illnesses or medical conditions which may affect the applicant's ability to provide long term care for a child or young person? *(please provide full details)*

Details

Are there any currently prescribed medication or treatment which may affect the applicant's ability to provide long term care for a child or young person? *(please provide full details)*

Details of use

Medical check form for guardians

Are there any medical conditions for which the applicant is not receiving treatment? *(please provide full details)*

Details

Does the applicant have a disability which may affect his/her ability to provide daily care? *(please provide full details)*

Details

Has the applicant suffered any serious illness or injury in the past which may affect his/her mobility, capacity to lift or other functioning? *(please provide full details)*

Details

Are you aware of any past or present psychiatric conditions with regards to the applicant which may impact on his/her potential to care for a child or young person now and in the future? *(please provide full details)*

Details

Medical check form for guardians

Are you aware of any past or present substance abuse issues and if so is treatment occurring or being sought? *(please provide full details)*

Details

Do you have any other comments relevant to the applicant's ability to provide daily care? *(please provide full details)*

Details

Signature	Date