**Request for Mental Health Information**

Name of Applicant:

The individual named above has requested for Families on the Mend LLC to consider him/her as applicants to adopt from the foster care system.

Please keep in mind that many foster children have experienced personal trauma such as abuse, neglect or abandonment. These children require a great deal of patience and nurturing. They are often very active and may exhibit challenging behavior requiring much energy and commitment on the part of the pre-adoptive parent. Please attach an additional page if necessary to provide all pertinent information.

1. The person named above has attended an appointment within the past twelve months.

YES NO Date of last appointment:

Please describe any mental health or emotional diagnosis:

1. Is the individual emotionally able to perform the essential parental function on a full-time basis?

YES NO

If no, please describe any limitations or concerns:

1. Does the individual’s present condition currently pose a significant risk (i.e. high probability of substantial harm) to the health or safety of children or others?

YES NO

If yes, please provide the following information:

The duration of the risk: \_\_\_\_\_\_\_ \_\_

The nature and severity of the potential harm: \_\_\_\_\_\_\_\_\_ \_\_

The likelihood the potential harm will occur:

Does the individual’s current condition present a risk at some time in the future?

If risk is involved, please state – if possible – when this risk will present itself:

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1. Are any reasonable accommodations available which could eliminate the risk of potential harm to an acceptable level; if necessary?

1. Please date and provide information about the latest episode experienced by the patient while under your care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Please describe any additional information which you feel may be relevant to the client becoming an approved pre-adoptive parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list any medications patient has been prescribed and dosages and include any noted side effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I certify that the above information is based on my reasonable medical judgment and the most current medical knowledge and/or the best available objective evidence regarding the condition of the named individual.*

Physician’s Signature Date

Please use the space below to PRINT the physician’s name and office address:

Physician’s Name:

Address:

City/State/Zip:

Telephone: