Medical Assessment Form

To be completed by the applicant's GP

Government of **Western Australia**
Department for **Child Protection**

FOSTERING
it's not just the child's life that changes

Please address all questions (write n/a if not applicable)

1. Applicant's Name | 2. Applicant's Date of Birth

3. Are you the applicant's usual GP? ☐ Yes ☐ No

4. How long have you known the applicant?

5. How would you rate the applicant's current health?

6. To your knowledge has the applicant had any of the following?

☐ Y	☐ N	High Blood Pressure	Year	
☐ Y	☐ N	Chest Pain	Year	
☐ Y	☐ N	Rheumatic Fever or Heart Condition	Year	
☐ Y	☐ N	Asthma, TB or Lung Disease	Year	
☐ Y	☐ N	Hearing or Speech Difficulties	Year	
☐ Y	☐ N	Visual Difficulties	Year	
☐ Y	☐ N	Diabetes (Type 1 or 2)	Year	
☐ Y	☐ N	Cancer or Tumour of any kind	Year	
☐ Y	☐ N	Ulcers (stomach or other)	Year	
☐ Y	☐ N	Major Surgery	Year	
☐ Y	☐ N	Depression and/or Anxiety	Year	
☐ Y	☐ N	Psychological/Psychiatric Disorders	Year	
☐ Y	☐ N	Epilepsy/ Fainting Attacks/ Fits	Year	
☐ Y	☐ N	Muscular/Skeletal Disease/Arthritis	Year	
☐ Y	☐ N	Bowel/Liver/Gall Bladder Disease	Year	
☐ Y	☐ N	Kidney or Bladder Disease	Year	
☐ Y	☐ N	Blood Born Virus (eg Hep C, HIV)	Year	
☐ Y	☐ N	Other - please specify	Year	
☐ Y	☐ N	Any medication taken not prescribed by a medical practioner	Year	

7. Does the applicant have an injury that is like to be aggravated by lifting children? ☐ Y ☐ N

If yes, please provide details

8. Has the applicant consulted a specialist in the last 2 years? ☐ Y ☐ N

If yes, please provide details

9a. Has the applicant ever been treated or currently being treated for any psychiatric illness, psychological condition or anxiety/depressive illness? ☐ Y ☐ N

If current, please specify any condition, treatment, management and medication

9b. How does this effect their daily functioning eg ability to work?

9c. If any past illness, please specify when this occurred, duration of illness, the management and treatment prescribed

9d. What likelihood is there of the condition reoccurring? Will this affect the applicant's ability to care for foster children?

10. Has the applicant any physical or sensory impairments or disabilities that you believe would inhibit their ability to provide good nurturing care to foster children? ☐ Y ☐ N

If yes, please provide details

11. Has the applicant had any gynaecological or fertility issues? ☐ Y ☐ N

If yes, please provide details

12a. Is there any past or present evidence of alcohol or drug abuse? ☐ Y ☐ N

If yes, please provide details

12b. If they have resolved this, please indicate how

13. If able, please make a comment on the applicant's emotional health and any other personality characteristics you consider relevant?

14. Do you know anything about the applicant's lifestyle which might impair their capacity to care for a child safely? ☐ Yes ☐ No

If yes, please provide details

15. Is there any other information that you consider relevant to this application (eg domestic violence? ☐ Yes ☐ No

If yes, please provide details

Do we have your permisson to discuss the above information with the applicant? ☐ Yes ☐ No

Doctor's Name

Provider Number

Phone Number

Submit by Email

Print Form