State of Rhode Island

Rhode Island Department of Children, Youth and Families

Medical Health History Form/Reference

As being a foster parent is frequently a physically and emotionally demanding job, the Department of Children, Youth and Families is interested in the health of the applicant. In order that we may expedite the processing of the application, we ask that a Physician, Physician's Assistant or Nurse Practitioner complete this form at your earliest convenience and return it to:

DCYF Foster Care Licensing
101 Friendship Street; Providence, RI 02903

Date of Referral: _____

An application to be a foster parent has been received from: _____
Applicant's Name

<table>
<tr><td colspan="3">What is your history with this patient?</td><td colspan="2">☐ New Patient</td><td>☐ Returning patient</td></tr>
<tr><td colspan="6">Has the patient disclosed or are you aware of any:</td></tr>
<tr><td colspan="2">…chronic disease or illness?</td><td colspan="2">…history of substance abuse?</td><td colspan="2">…history of mental illness?</td></tr>
<tr><td>☐ Yes</td><td>☐ No</td><td>☐ Yes</td><td>☐ No</td><td>☐ Yes</td><td>☐ No</td></tr>
<tr><td colspan="6">If yes to any of the above, please explain:</td></tr>
<tr><td colspan="4">To your knowledge, is the patient currently prescribed or taking any medications (including medicinal marijuana)?</td><td>☐ Yes</td><td>☐ No</td></tr>
<tr><td colspan="6">If yes, please list:</td></tr>
<tr><td colspan="4">Do you consider the patient physically competent to be a foster parent?</td><td>☐ Yes</td><td>☐ No</td></tr>
<tr><td colspan="6">If no, please explain:</td></tr>
<tr><td colspan="6">Any additional comments:</td></tr>
<tr><td colspan="6">Print Medical Professional Name & Address:</td></tr>
</table>

_____ _____
Signature *Date*

Please note: The DCYF form #007B, "Authorization to Obtain Confidential Information" shall be forwarded to the medical professional along with this form.