

Health report for adults being assessed to become adoptive parents or foster carers

This form is suitable to use for all fostering and adoption applications, including intercountry adoption/special guardianship/short break/respite care/kinship care, and can also be used when a full medical review is required for carers who are already approved.

A commissioning letter from the fostering/adoption agency should accompany this form.

Guidelines and process for completion

Part A - to be completed by the agency

It should clearly identify where the form should be returned when all sections are completed.

Part B - to be completed by the applicant/carer

Confidentiality and storage On completing part B/section 5, the applicant/carer confirms that they give consent for their health information to be shared with the agency. The health report will be stored confidentially on their social care record.

Part C - to be completed by a medical practitioner, usually the applicant's/carer's own GP

The purpose of the completion of the medical report on the applicant is to obtain accurate and up-to-date information on the applicant's individual and family health history and current physical and mental health. The medical practitioner completing Part C is not required to make a decision on suitability but to provide sufficient accurate and detailed information to enable the agency medical adviser to advise the agency. This information will assist the agency in deciding the applicant's suitability to care for the child. It is important that the GP record is available to the assessing practitioner. Safeguarding concerns should be disclosed.

The agency medical adviser should be contacted if the doctor completing the form wishes to discuss any issues arising from the health assessment. **Part C is preferably completed in person but video consultation is an option.** For more information visit corambaaf.org.uk/formah-gp

Part D - to be completed by the agency medical adviser

Interpretation of Adult Health Report by agency medical adviser

On receipt of the completed AH form, the medical adviser will provide a summary, and advice to the agency on the implications of an applicant's current health and history. Further information for medical advisers is available at corambaaf.org.uk/formah-ma.

Why is this information needed?

The requirements to obtain information about prospective adoptive applicants and foster carers are laid down in the relevant adoption and fostering Regulations for England, Northern Ireland, Scotland and Wales, and this includes details about the health status of those applying to adopt or foster. Many children who are in the care system (looked after children) have a history of neglect and/or physical, sexual or emotional abuse and other adverse experiences. They are therefore likely to have a range of significant individual needs.

Prospective adopters and carers must have robust physical and mental health to be able to parent these vulnerable children. Health information about prospective adopters or foster carers and its interpretation form only one part of the application and supervision process and will be set alongside other information obtained by the agency in considering the suitability of applicants. The application process involves a panel making recommendations. It is unusual for health issues to prevent approval as carers/parents. The information provided is also used to assist appropriate matching of carers and children.

It is important that agencies satisfy themselves that applicants are able to meet the demands of parenting on a daily basis, and in the case of adoption and long-term placements, have a reasonable expectation of retaining good health to support children to adulthood.

Form AH ADULT HEALTH REPORT

CONFIDENTIAL

Page 1

Name of applicant

DoB

PART A to be completed by the adoption/fostering agency – in black ink or preferably electronically

Health report for a (tick as appropriate)

first application

☒

review

☐

Please indicate caring role below

Fostering

☐

tick if long term

☐

Short break/respite care

☐

Adoption

☒

Intercountry adoption

☐

Special guardianship

☐

Kinship/connected person

☐

Other care

☐

Ages and number of children applied for (if specific child, provide details)

Name of agency	Parents and Children Together (PACT)	Social worker	
Address	7 Southern Court, South Street, Reading		
Telephone	0118 9387600	Postcode	RG1 4QS
Email	info@pactcharity.org		
Case reference number			
Name of medical adviser	Dr E Johnson/Dr E McCartney		
Employed by	Parents and Children Together		
Address	7 Southern Court, South Street, Reading, RG1 4QS		
Telephone	0118 9387600		
Email	Sandra.leach@pactcharity.org		

RETURN FORM when Parts B and C are complete TO

Name	Sandra Leach	Designation	Business Support Team Manager
Email	Sandra.leach@pactcharity.org		
Post to	Sandra Leach, Parents and Children Together, 7 Southern Court, South Street, Reading, RG1 4QS		

Form AH ADULT HEALTH REPORT

CONFIDENTIAL

Page 2

Name of applicant

DoB

PART B to be completed by the applicant

1. Applicant details

Information about your health will be used to assist the application; matching and support processes. Please try to give as much accurate information as possible.

Family name			
First name		Gender	
Address			
Tel		Email	
Date of birth		Occupation	
NHS number		Ethnicity	
GP details Name and address			
Have you ever lived outside of UK? Enter dates			
Name of partner if applying jointly			

2. Current health

Do you consider yourself to be in good health currently?	Yes/No
Please give details	
Are you seeing any specialists or hospital consultants?	Yes/No
If yes, give details of who you see and where	

Form AH ADULT HEALTH REPORT

CONFIDENTIAL

Page 3

Name of applicant

DoB

What do you see him/her for?	
Do you attend the GP for regular appointments?	Yes/No
If yes, what are these appointments for?	
Do you take any medication regularly? (including sourced from an online provider)	Yes/No
If yes, please list below and clarify what each is for	
SAMPLE	
Have you had any health issues in the past?	Yes/No
If yes, please give details	

Form AH ADULT HEALTH REPORT

CONFIDENTIAL

Page 4

Name of applicant

DoB

Have you had any emotional or mental health problems such as anxiety, depression or stress?	Yes/No
If yes, please give details. Include any life events that may have been triggers	
Do you have any significant sleep difficulties?	Yes/No
Have you ever seen a psychiatrist/psychologist/psychotherapist/counsellor/psychiatric nurse/other health or social work professional or complementary therapist for issues related to mental health?	Yes/No
If yes, please give details and dates	
Are you awaiting an appointment regarding your mental health and emotional well-being?	Yes/No
If yes, please provide details and dates	
Have you ever attended a private health clinic or hospital?	Yes/No
If yes, provide details and dates	
Are you on any benefits related to sickness, incapacity or disability?	Yes/No
If yes, please give details	

Name of applicant

DoB

Do you have any dental problems? How often do you attend the dentist?	
Do you have any significant problems with your vision or hearing?	

3. Family history

Provide details about the health of your family. Does anyone have any serious health problems? Does anyone have any genetic conditions that may run in the family?

	Age	State of health if living (if known)	Age at death and cause (if known)
Father			
Mother			
Brothers and sisters			
Children			
Other (please specify)			

4. Lifestyle

What exercise or activity do you do?	How long for and how often?
Describe your diet and any dietary restrictions	
What do you feel keeps you healthy?	

Form AH ADULT HEALTH REPORT

CONFIDENTIAL

Page 6

Name of applicant

DoB

Do you smoke tobacco? (cigarettes, pipe, roll-ups)	Yes/No
If yes, how long have you smoked?	
How many do you smoke per day?	• Less than 1 • 1-5 • 6-10 • 10 +
If NO, have you ever smoked tobacco?	Yes/No
How many years did you smoke for?	
When did you stop smoking?	
Do you currently use an electronic cigarette (vaping device)?	Yes/No
Do any other household members smoke?	
Where are visitors/household members allowed to smoke in your home?	
How many nights a week do you drink alcohol?	
How many units of alcohol do you drink on an average week? You can calculate units here	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down? When/Why?	
Have you ever used recreational/street/illegal drugs?	Yes/No
If yes, please describe use, including when and type of substance	
What is your current weight?	
What is your current height?	
Please describe whether you have had any fertility treatment?	
What were the dates of this treatment?	
Have you accessed any counselling in relation to the treatment? If so, please give details, and say whether this continues	

Name of applicant**DoB****Please describe your pregnancy history, including any pregnancy losses**

5. Consent

I certify that to the best of my knowledge the above information is complete and accurate.

I understand that the information about my medical history and present medical condition recorded on this form is required by the named agency.

I consent to a medical examination, and for the examining medical/health practitioner to access my medical records.

I consent to the provision of this report to the agency, understanding that it will be viewed by relevant staff and the agency medical adviser and will be stored confidentially by the agency.

I consent to the agency medical adviser viewing my electronic health record and requesting further information from my GP/health practitioners involved in my care if required.

I understand that I am responsible for informing the agency if there are any significant changes to my health.

Signature of applicant**Date**

Name of applicant

DoB

PART C to be completed by an appropriate health professional, usually the applicant's GP

In adoption, the report must be completed by a medical practitioner. This form will be viewed by the commissioning agency including the applicants' social worker and the medical adviser for the agency. For more information visit corambaaf.org.uk/formah-gp

Please review the information provided by the applicant in Part B and complete the following sections 1 to 6.

The applicant has completed Part B, a questionnaire about their own health, and I have had the opportunity to review this information as part of this assessment	Y/N
Please comment on accuracy of self-reported information	

1. General

Are you the applicant's usual GP? If not, explain current role
How long have you known the applicant? How long have you treated the applicant?
At what date do their records (please consider written and computerised records) begin?
Do the records appear to be continuous? If not, please provide details of any breaks.

Name of applicant

DoB

Safeguarding

Do you know anything about the applicant's lifestyle/health/history that might impact their capacity to care for a child or put a child's welfare at risk? (Please review all records available and consider problematic drug and alcohol use).

Yes/No

Please give details.

Has a GP previously completed a medical report for adoption and fostering purposes for this applicant/carer, according to records?

When and for what purpose did they last consult your practice?

Are they currently receiving any treatment/care for current health issues?

Are they currently receiving/being prescribed any medication or other treatment?

If yes, please specify

2. Medical history

Please give details of any conditions (including treatment and investigations, dates and duration) or write NONE

Medical conditions

Name of applicant

DoB

Previous surgery/planned surgery
Trauma/accidents
Pregnancy history/history of infertility treatment. <i>(Applicants are encouraged to discuss these experiences with their social worker, particularly when considering adoption). Include detail, giving consideration to type of application.</i>
Infectious diseases (current or previous and significant) e.g. Hepatitis C, Hepatitis B, HIV, TB (include test results and treatment details)
Immunisations (Hepatitis B immunisation is recommended for foster carers and intercountry adopters)
Has been vaccinated as per recommended schedules (including flu/Covid) Y/N
Comments:
Hepatitis B vaccination previously Y/N
BCG vaccination previously Y/N

3. Mental health

Any history of mental illness/mental health problems (includes anxiety, stress, personality disorders, self-harm and psychoses). List episodes with dates and diagnoses. Please include details of identified triggers
Have they ever received medication for a mental health issue? Please give details, including duration of treatment

Name of applicant

DoB

Any psychiatric or psychological treatment or counselling/psychotherapy? (Specify and give dates and duration)

Any emotional/relationship problems?

Have there been any periods of not being able to work due to mental health issues? If yes, please give details

If there have been mental health difficulties/emotional problems, how would you assess the applicant's present condition?

4. Consultations

Provide details of past and present consultations with specialists.

	Specialist's name	Hospital and patient reference number	Reason/details/dates
Past			
(if relevant)			
Present			

Please send copies of hospital and consultant reports with the completed form (from last 5 years and more historical if relevant)

Name of applicant

DoB

5. Examination

Measurements (in light clothes)	Height		cm
	Weight		kg
Body Mass Index (BMI)			
If BMI > 30, take waist measurement	Waist circumference		cm
If BMI is over 30 what is the plan to follow this up? Is there a weight reduction plan?			
Blood pressure:			
Please take urine sample (essential)	Result		
Please complete cardiovascular risk score (if indicated)			
Is further physical examination indicated giving consideration to history, baseline measurements, presentation or patient concerns? If so, please record			
Any further clinical findings or recommendations? Have you arranged for further investigations/treatment resulting from this appointment?			

6. Impact of physical and mental health

Please comment on how the applicant/carer copes physically and mentally with any chronic condition, e.g. management of condition, ability to work, limitation in daily activities, and how this may affect parenting capacity.

Is patient in receipt of health related benefits?	Yes/No
Do chronic health conditions limit daily activities?	Yes/No

Form AH ADULT HEALTH REPORT

CONFIDENTIAL

Page 13

Name of applicant

--

DoB

--

How may chronic health conditions impact parenting capacity?

Name				
GMC Registration number		Qualifications		
Address				
			Postcode	
Telephone				
Email – Please provide surgery e-mail address				
How was Part C completed? (tick as appropriate)		in person		via video consultation

Signature		Date	
------------------	--	-------------	--

Form should be returned as per the instructions on the bottom of page 1 Part A.

Please do not return this form under any circumstances to CoramBAAF

Name of applicant

DoB

PART D Summary report from agency medical adviser

(this may be completed on a separate document depending on local arrangements)

This will be entered into Form F/the Prospective Adopter's Report and read by the panel and applicant.

Further information for medical advisers is available at corambaaf.org.uk/formah-ma

Summary of health and lifestyle issues with comments on the significance for adoption/fostering.

SAMPLE			
Name		Designation	
Qualifications			
Address			
		Postcode	
Email		Telephone	
Signature		Date	