Washington State Department of CHILDREN, YOUTH & FAMILIES

LICENSING DIVISION (LD)

ኣመልካቲ ሕክምና ሪፖርት ምሽጥራዊ

Applicant Medical Report CONFIDENTIAL

Section 1: Completed by Applicant
ክፍሊ 1: ብኣመልካቲ ዝተዛዘመ

MEDICAL PROVIDER NAME
ሕክምና ኣቕራቢ ሽም

PHONE NUMBER ቁጽሪ ተሌፎን	FAX NUMBER ፋክስ ቁፅሪ

ADDRESS OR NAME AND LOCATION OF MEDICAL OFFICE/PRACTICE/CLINIC
ኣድራሻ ወይ ስምን ቦታን ቤት ጽሕፈት ሕክምና/ፕራክቲስ/ክሊኒክ

NAME OF APPLICANT ስም ኣመልካቲ	DATE OF BIRTH ዕለት ልደት

I hereby authorize my medical provider to release my medical history information including, but not limited to, information on the issues I have checked below. This information is required as part of a home study for foster care and/or adoption. This release of information is valid for one year from the date of my signature.

NOTE: Be sure to check each line and sign.

☐ mental health
☐ alcohol and drug concerns
☐ sexual and/or physical abuse
☐ domestic violence

በዚ ኣገባብ እዚ ንወሃቢ ሕክምናይ ናይ ሕክምና ታሪኽ ሓበሬታ ሓዊሱ፡ ግን ከኣ ኣብዚ ጥራይ ዝተሓጽረ ዘይኮነ፡ ኣብ ታሕቲ ዝፈተሽኩዎም ጉዳያት ዝምልከት ሓበሬታ ክዝርግሕ ስልጣን እህቦ። እዚ መረዳእታ ከም ሓደ ኣካል ናይ ገዛ ጽንዓት ንናብዮት/ሕጋዊ ምዕባይ ዘድሊ እዩ።
እዚ ምውጻእ ሓበሬታ ካብ ዝፈረምኩሉ ዕለት ጀሚሩ ንሓደ ዓመት ዝጸንሕ እዩ።

መዘኽርታ: ነፍሲ ወከፍ መስመር ምፍታሽን ምፍራምን ርግጸኛ ኩን።

☐ ጥዕና ኣእምሮ
☐ ጾታዊን/ወይ ኣካላዊ መጥቃዕቲ
☐ ስክፍታታት ኣልኮላዊ መስተን ዕጸፋርስን
☐ ዘቤታዊ ዓመጽ

SIGNATURE OF APPLICANT ናይ ኣመልካቲ ኪታም	DATE ዕለት

Section 2: Completed by LD/CPA Staff
ክፍሊ 2: ብሰራሕተኛታት LD/CPA ዝተዛዘመ

LICENSOR NAME ስም ፍቓድ ዝሃበ	LICENSING DIVISION OFFICE MAILING ADDRESS AND FAX NUMBER ቤት ጽሕፈት ክፍሊ ፍቓድ ናይ ፖስታ ኣድራሻን ቁጽሪ ፋክስን

Section 3: Completed by Medical Provider. Return to local Licensing Division office listed in Section 2.
ክፍሊ 3: ብሕክምናዊ ወሃቢ ዝተዛዘመ። ናብቲ ኣብ ክፍሊ 2 ዝተዘርዘረ ናይ ከባቢኻ ቤት ጽሕፈት ክፍሊ ፍቓድ ተመለስ።

DATE OF MOST RECENT PHYSICAL EXAMINATION (**MUST BE WITHIN 12 MONTHS OF APPLICATION**) ኣብ ቀረባ እዋን ኣካላዊ መርመራ ዝተገብረሉ ዕለት **(ካብ ምምልካት ኣብ ውሽጢ 12 ኣዋርሕ ክኸውን ኣለዎ)**	DATE FIRST SEEN BY PROVIDER ብኣቕራቢ ዝተርኣየሉ ናይ ፈለማ ዕለት

CHRONIC / FREQUENT MEDICAL ISSUES (INCLUDING SIGNIFICANT PAST MEDICAL HISTORY)
ሕዱር/ዝደጋገም ናይ ሕክምና ኩነታት (ናይ ሕሉፍ ናይ ሕክምና ታሪኽ ሓዊሱ)

CURRENT MEDICAL DIAGNOSIS
ናይ ሕዚ ሕክምና ምርመራ

CURRENT MEDICATIONS: PLEASE STATE THE PURPOSE OF THE MEDICATION, ANTICIPATED SIDE EFFECTS AND CONCERNS IF THE MEDICATION IS NOT TAKEN, AND HOW IT AFFECTS DAILY FUNCTIONING
ናይ ሕዚ መድሓኒት፡ ብኽብረትካ ናይቲ መድሓኒት ዕላማ፣ ትጽቢት ዝግበረሉ ጽልዋን እቲ መድሓኒት እንተዘይተወሲዱ ዘለዎ ጸገምን ዕለታዊ ምንቅስቓስ ብኸመይ ጽልዋ የሕድር።

PROGNOSIS
ቅድመ ግምገማ

PLEASE DESCRIBE HOW ANY MEDICAL CONDITION AFFECTS THE CARE OF ADDITIONAL CHILDREN
ብኽብረትካ ዝኾነ ዓይነት ናይ ሕክምና ኩነታት ከም ዝፀ

COMMENTS/ IMPRESSIONS: IS THE APPLICANT CAPABLE OF CARING FOR AN ADDITIONAL CHILD OR CHILDREN?
ርኢቶታት/ትዕዝብትታት፡ እቲ ኣመልካቲ ንተወሳኺ ህፃን ወይ ህፃናት ንምክንኻን ብቑዕ ድዩ?

SPECIALIST REFERRED TO (IF APPLICABLE)
ሪፈር ዝተገበረሉ ስፔሻሊስት (ዝምልከት እንተድኣ ኮይኑ)

FAX NUMBER OF SPECIALIST (IF APPLICABLE)
ናይ ስፔሻሊስት ፋክስ ቁፅሪ (ዝምልከት እንተድኣ ኮይኑ)

REASON FOR REFERRAL (IF APPLICABLE)
ናይ መወከሲ ምኽንያት (ዝምልከት እንተድኣ ኮይኑ)

MEDICAL PROVIDER SIGNATURE
ሕክምና ኣቕራቢ ኪታም

MEDICAL PROVIDER NAME ሕክምና ኣቕራቢ ሽም	SIGNATURE ኪታም	DATE ዕለት