



Domestic Infant Adoption | Counseling Report

PERSON TO BE ADDRESSED IN THIS REPORT:

Full Name _____

Date of Birth _____

RETURN COMPLETED FORMS TO :

Children's Home & LSS
ATTN: Domestic Infant Adoption Program
1605 Eustis Street, Saint Paul, MN 55108
infantapp@chlss.org | Fax: 651.646.0436

I agree that the findings of this report can be shared with Children's Home & Lutheran Social Service of Minnesota. I authorize Childre's Home & LSS to have ongoing written and verbal contact with the provider listed below. This consent is valid for one year from the date of signature. I understand and agree that my electronic signature is the legal equivalent of my manual/handwritten signature on this document and is as valid as if I signed the document in writing.

PERSON ADDRESSED IN REPORT | Signature _____ Date _____

Please have a provider complete the following report for the above-named adult.

Dates of service & Length of treatment _____

Diagnoses:

Areas of focus for your work together:

Progress and current prognosis:

Impression of emotional maturity and ability to function as foster and/or adoptive parent:

To the best of my knowledge, I have disclosed all compromising information about the above-named person.

PROVIDER | Signature _____ Date _____

Physician Name & License:

Clinic Address: