Adoption Services Victoria

Apply for the Forced Adoption Exceptional Circumstances Fund

FORM THREE: Medical Statement

# About this form

Please complete your details as the patient then provide this to your medical professional to complete the Statement.

The patient indicated below has made an application to the **Forced Adoption Exceptional Circumstances Fund** administered by the Victorian Government.. For your patient to access funding, you are asked to complete this form in support of their eligibility.

Exceptional circumstances may include terminal or critical illness.

Applicants to the Forced Adoption Exceptional Circumstances Fund who are terminally ill will be prioritised.

You do not need to provide details of their condition or treatment, only that in your professional opinion, they meet the definition below.

You may either return this form to your patient or submit the completed form directly via:   
• Email to [forcedadoptioninquiry@justice.vic.gov.au](mailto:forcedadoptioninquiry@justice.vic.gov.au) or

• Post to Forced Adoption Exceptional Circumstances Fund, GPO Box 4332, Melbourne, VIC, 3001.

# Patient details

|  |  |
| --- | --- |
| Patient’s full name |  |
| Patient’s date of birth |  |

# Statement by medical professional

I am a doctor or other medical professional providing treatment to the patient whose details are listed above. I understand the patient has made an application to the Forced Adoption Exceptional Circumstances Fund and is seeking a payment due to their health condition.

In my professional opinion the patient is either:

Terminally ill or

Critically ill, in that they have an illness that is:

* 1. a life-threatening illness, and
  2. likely to materially impact their condition within six months from the date they submit their application, such that they would be prevented from having the full benefit of any payment made to them if they had to wait.

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## Medical professional details

|  |  |
| --- | --- |
| Title |  |
| Full name |  |
| Medical profession (e.g. Doctor, Palliative Care Nurse, Psychologist) |  |
| Registration number |  |
| Phone number |  |
| Email address |  |
| Postal address |  |
|  |  |
|  |  |

|  |  |
| --- | --- |
| Your signature |  |
| Today’s date (dd/mm/yyyy) |  |