FOR CLERK'S USE ONLY

CONFIDENTIAL MEDICAL REPORT

HEALTH PROFESSIONAL'S REPORT

Instructions to Petitioner: **This form must be completed if you are seeking appointment as a guardian and/or conservator.**

1. Fill in the information on this page only and give this document to the physician, registered nurse, or psychologist/psychiatrist you propose to evaluate the health of the person you believe needs a guardian or conservator.

2. File the completed form with the Clerk of Superior Court as a separate document. Do not attach it to any other document.

3. Copies must be given to the attorney for the Subject Person no later than five days before the hearing.

Court Case Number: _____

Name of Evaluator: _____

Name of Patient
(Subject of This Evaluation): _____ (Alleged incapacitated person or person in need of protection)

Name of Petitioner: _____

Petitioner's Telephone Number: _____

Date and Time of Court Hearing: _____

Case No. _____

Instructions to Physician or Other Evaluator: A court case has been filed that asks the court to appoint a guardian and/or conservator for the person named as "Patient" above. The Court needs the opinion of a medical professional to make that decision.

If you do not have enough space on this form to answer, write in "See attached" and respond on separate page.

If this report recommends that the Patient is likely to need inpatient mental health treatment in the next year, then this report must be signed by a licensed psychologist or psychiatrist.

After you complete the report, give the original report to the Petitioner, who is responsible for filing the report with the court and distributing copies to the parties.

The Court realizes that your time is valuable. Thank you for your time and assistance.

Questions for Health Professional to Answer:

1. What is the date you last saw the Patient?_____
   (Include date of this report if the Patient seen that date)

2. How long have you been treating the Patient? _____

3. Who asked you to do this evaluation ? _____

4. I am a: ☐ Physician ☐ Psychologist ☐ Nurse Practitioner ☐ Registered Nurse
   ☐ Other: _____

5. What is your area of specialty? _____
   Are you Board Certified in this area? ☐ Yes ☐ No
   In any other areas? ☐ Yes ☐ No
   If "yes," list:_____

6. Is the Patient impaired by any of the following?

   ☐ Mental illness, deficiency, or disorder
   ☐ Physical illness or disability
   ☐ Chronic intoxication or drug use
   ☐ Other

7. Please provide a specific description of each physical, psychiatric or psychological diagnosis causing impairment:

_____

_____

_____

_____

8. Has the Patient been treated or hospitalized before for this difficulty?

☐ Yes ☐ No

If yes, when and where?

_____

_____

_____

_____

9. Is the Patient able to do the following things? Please check each applicable box.

☐ Pay their bills
☐ Obtain food
☐ Live alone
☐ Make appropriate judgments that will protect them personally, physically, or financially
☐ Take medication appropriately
☐ Provide adequate housing
☐ Exercise daily self-help skills

Voting rights:

Does the Patient have sufficient capacity and understanding to express a preference on a ballot?

☐ Yes ☐ No

Please explain:

_____

_____

_____

_____

Driving privileges:
Is the Patient capable of safely operating a motor vehicle?
☐ Yes ☐ No

Please explain:

_____

_____

_____

10. If the Patient is currently on medication, please list those medications:

_____

_____

_____

_____

11. Do you believe that the medication is affecting the Patient's ability to respond coherently?
☐ Yes ☐ No

12. Do you believe that the medication is affecting the Patient's ability to ambulate?
☐ Yes ☐ No

13. Do you believe that a "medication holiday," if possible, would help you better evaluate the Patient? ☐ Yes ☐ No

14. Do you believe that any changes made in the type or amount of drugs the Patient is receiving would noticeably affect their mental or physical abilities? ☐ Yes ☐ No

15. Do you believe that any further medical evaluation or treatment would benefit the Patient? ☐ Yes ☐ No

Please explain:

_____

_____

_____

_____

16. Do you think the Patient would benefit from other types of therapy such as counseling?

☐ Yes ☐ No

If yes, describe:

_____

_____

_____

_____

17. Which of the following are appropriate placements for the Patient today?

☐ Independent living
☐ At home with a companion
☐ At home with a nurse
☐ In a group home
☐ In an assisted living facility
☐ In a memory care facility
☐ In a skilled nursing facility
☐ In a hospital
☐ In an Inpatient Psychiatric Facility
☐ Other - please explain:_____

_____

_____

18. In your opinion, what is the least restrictive living arrangement appropriate for the Patient?

_____

_____

_____

_____

19. Give a comprehensive assessment of any functional impairments of the Patient:

_____

_____

_____

_____

20. How and to what extent do these impairments affect the Patient's ability to receive or evaluate information needed in making or communicating personal and financial decisions?

_____

_____

_____

_____

21. What tasks of daily living is the Patient capable of performing without direction or with minimal direction?

_____

_____

_____

_____

22. What is the most appropriate rehabilitation plan and/or care plan for the Patient?

_____

_____

_____

_____

23. Is there any reason why this Patient should not personally appear in court?

☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

_____

24. Do you believe that the Patient's condition could improve within 6 months to a year?

☐ Yes ☐ No

25. Is there is any reason for the court to review this matter again within less than one year?

☐ Yes ☐ No

Case No. _____

Mental Health Treatment Questions

This section must be completed if the Petitioner is requesting that the guardian be granted the authority to consent for the Patient to receive inpatient mental health treatment, and if so, this report or a separate report addressing this information must be signed by a licensed psychologist or psychiatrist.

1. Is it the opinion of the undersigned that the Patient is incapacitated as a result of a mental disorder? ☐ Yes ☐ No
2. What is the mental disorder? _____
3. What kind of treatment is the Patient currently receiving for this mental disorder?

   _____

   _____

   _____
4. Is it the opinion of the undersigned that the Patient is likely to need inpatient mental health care and treatment within the next year? ☐ Yes ☐ No

   If yes, the undersigned must be a licensed psychologist or psychiatrist.

   If yes, please explain: _____

   _____

   _____
5. Please make any additional comments or suggestions you feel would be valuable to the court: _____

   _____

   _____

   _____

Date report was prepared: _____

_____

Signature

_____

Printed Name, Professional Title (M.D., R.N., Ph.D., etc.)