

Chancery No. _____

PHYSICIAN’S EVALUATION REPORT

NOTE: *This report will be used as evidence in a legal proceeding to appoint a guardian and/or conservator for the person named below. The information set forth must be based on your personal examination of the patient. Please respond to each issue as appropriate including the nature, cause, extent, and probable duration of any physical or mental disability that the person may have which interferes with his or her ability to make responsible decisions about their health care, food, clothing, shelter, or property. Your testimony about this information may be required at a court hearing; however, if this report is fully completed, it substantially reduces the probability that you will be called to testify at the hearing.*

Patient’s Full Name: _____

Patient’s Address: _____

Physician Information

I, _____, graduated in _____ from the _____, School of Medicine. I am licensed to practice medicine in _____. I am board certified in _____, and my specialty is _____. I first saw this Patient on _____ and last saw him on _____ as this Patient’s regular physician consulting physician (Circle one). I personally examined this Patient on _____, at what time I performed or ordered the following tests:

Patient Information

The Patient exhibited the following symptoms:

Physical: _____

Mental: _____

The Patient (*Check One*)

is not on any medications that may affect his actions or mental condition.

is on medications which may affect his action or mental condition

Medications: _____

Effect: _____

Based on my examination of this patient, it is my opinion that he or she:

does not have a mental condition that interferes with his ability to make or communicate responsible decisions concerning health care, food, clothing, shelter, or the maintenance of their property. (*If this is your opinion, you do not have to complete the rest of this form, please go to the signature page and sign the certificate*)

does have a mental condition that interferes with his ability to make or communicate responsible decisions concerning health care, food, clothing, shelter, or the maintenance of their property.

The nature of this disability is:

The cause of this disability is:

The extent of the disability is:

The usual treatment for this disability is:

The patient retains the ability to:

The patient has the ability to be rehabilitated and learn the following self care skills:

The patient [] **does** [] **does not** require institutional care.

[] In my opinion the patient has a disability which prevents him or her from making or communicating **any** responsible decisions concerning his or her **person**.

(Or)

[] In my opinion the patient has a disability which prevents him or her from making or communicating **some** responsible decisions concerning his or her **person**.

(And)

[] In my opinion, the patient has a disability which prevents him or her from making or communicating **any** responsible decisions concerning his or her **property**.

[] In my opinion, the patient has a disability which prevents him or her from making or communicating **some** responsible decisions concerning his or her **property**.

(AND if applicable)

[] In my opinion the patient **does not** have sufficient mental capacity to understand the nature of a guardianship and **cannot consent** to the appointment of a guardian.

I certify that the foregoing responses are true to the best of my knowledge and belief.

(Date)

(Signature)