Evaluator's Name

Address

City, State, Zip

Phone

Email

I am a [ ] Physician [ ] Psychiatrist [ ] Other _____ licensed to practice in the state of _____. My License number is _____

Report on Clinical Evaluation of _____ (patient's name)

To the evaluator: This document may be filed in a court case to appoint a guardian for the patient, and it may be treated as evidence of the patient's incapacity. You may not be able to answer every question within the scope of your evaluation. Answer the questions for which you have information based on your personal observations, based on statements by the patient, or based on a source on which you commonly rely in your professional capacity.

1. Sources of information

I [ ] am [ ] am not aware of the patient's advance healthcare directive.

My answers are based on the following sources of information.

[ ] My examination of the patient on _____ (date) for the purpose of assessing capacity. On that date I spent about _____ minutes with the patient.

[ ] My general knowledge of the patient, who has been my patient since _____ (date) and who I last saw on _____ (date). On that date I spent approximately _____ minutes with the patient.

[ ] Review of the patient's records.

[ ] Discussions with the patient.

[ ] Discussions with healthcare professionals involved in the patient's care.

[ ] Discussions with the patient's family, friends or caregivers.

2. Overall condition

The patient's overall physical health is:

[ ] Excellent [ ] Good [ ] Fair [ ] Poor

The patient's overall physical health will:

[ ] Improve [ ] Be stable [ ] Decline [ ] Uncertain

The patient's overall mental health is:

[ ] Excellent [ ] Good [ ] Fair [ ] Poor

The patient's overall mental health will:

[ ] Improve [ ] Be stable [ ] Decline [ ] Uncertain

List your diagnoses that affect the patient's functioning.

	Level of Impairment				
3. Daily functions (If you check moderate or severe or if you have concerns, explain in the comments.)	None	Mild	Moderate	Severe	Not Evaluated
Activities of daily living (ADLs: bathing, grooming, dressing, mobility, toileting, eating, taking medication, etc)	[ ]	[ ]	[ ]	[ ]	[ ]
Instrumental Activities of Daily Living (IADLs: medication acquisition and monitoring, food shopping and preparation, transportation, paying bills, protect assets, resist fraud, etc.)	[ ]	[ ]	[ ]	[ ]	[ ]
Medical decision making (reason about health, express a choice, and understand, information, etc.)	[ ]	[ ]	[ ]	[ ]	[ ]
Care of home and functioning in community (manage home, health, telephone, mail, drive, leisure, etc.)	[ ]	[ ]	[ ]	[ ]	[ ]
Ability to protect self from harm, including physical harm, self-neglect, and financial exploitation.	[ ]	[ ]	[ ]	[ ]	[ ]
Comments					

	Level of Impairment				
4. Behavior (If you check moderate or severe or if you have concerns, explain in the comments.)	None	Mild	Moderate	Severe	Not Evaluated
Rambling, nonsensical, or incoherent thinking	[ ]	[ ]	[ ]	[ ]	[ ]

4. Behavior (If you check moderate or severe or if you have concerns, explain in the comments.)	Level of Impairment				
	None	Mild	Moderate	Severe	Not Evaluated
Confabulation (fills in memory gaps with honestly believed false information)	[ ]	[ ]	[ ]	[ ]	[ ]
Seeing, hearing, smelling things not there	[ ]	[ ]	[ ]	[ ]	[ ]
Extreme suspiciousness; believing things that are not true against reason or evidence	[ ]	[ ]	[ ]	[ ]	[ ]
Uncontrollable worry, fear, thoughts	[ ]	[ ]	[ ]	[ ]	[ ]
Acting without considering consequences	[ ]	[ ]	[ ]	[ ]	[ ]
Acting with hostility, anger or violence	[ ]	[ ]	[ ]	[ ]	[ ]
Disinhibition, sexual aggression, uncontrollable behavior,	[ ]	[ ]	[ ]	[ ]	[ ]
Refuses to accept help or follow directions	[ ]	[ ]	[ ]	[ ]	[ ]
Wandering	[ ]	[ ]	[ ]	[ ]	[ ]
Comments (Attach additional pages if necessary.)					

5. Cognitive and emotional impairment (If you check moderate or severe or if you have concerns, explain in the comments.)	Level of Impairment				
	None	Mild	Moderate	Severe	Not Evaluated
Alertness/consciousness	[ ]	[ ]	[ ]	[ ]	[ ]
Memory and cognitive functioning	[ ]	[ ]	[ ]	[ ]	[ ]
Emotional and psychiatric functioning	[ ]	[ ]	[ ]	[ ]	[ ]
In what areas are the patient's decision making or thinking impaired and to what extent?					

6. Risk of harm

How likely is the risk that the patient may harm self or others?

[ ] Unlikely [ ] Possible [ ] Probable [ ] Almost Certain

Describe any significant risks the patient faces and note whether these risks are due to the patient's condition and/or due to another person harming or exploiting the patient.

Describe any social factors (persons, supports, environment) that increase or decrease the risk.

7. Level of supervision needed

In your opinion, what level of supervision does the patient need?

[ ] No supervision [ ] Some supervision [ ] 24-hr supervision [ ] Locked facility

8. Treatment and accommodation

Describe treatments or accommodations that might enhance the patient's functioning and any that have been tried but are ineffective.

This report is complete and accurate to the best of my information and belief. If directed to do so, I am prepared to present to the court, by affidavit or testimony, my qualifications and my evidence.

Signature ►

Date

Printed Name

Certificate of Service

I certify that I filed with the court and am serving a copy of this Report on Clinical Evaluation on the following people.

Person's Name	Service Method	Service Address	Service Date
(Petitioner or Attorney)	[ ] Mail [ ] Hand Delivery [ ] E-filed [ ] Email [ ] Left at business (With person in charge or in receptacle for deliveries.) [ ] Left at home (With person of suitable age and discretion residing there.)		
(Respondent or Attorney)	[ ] Mail [ ] Hand Delivery [ ] E-filed [ ] Email [ ] Left at business (With person in charge or in receptacle for deliveries.) [ ] Left at home (With person of suitable age and discretion residing there.)		
	[ ] Mail [ ] Hand Delivery [ ] E-filed [ ] Email [ ] Left at business (With person in charge or in receptacle for deliveries.) [ ] Left at home (With person of suitable age and discretion residing there.)		

_____ Signature ► _____

Date

Printed Name _____