Physician's Certificate of Medical Examination

Revision June 2016

In the Matter of the Guardianship of

___________________________________,

an Alleged Incapacitated Person

For Court Use Only

Court Assigned:____________________________

To the Physician

This form is to enable the Court to determine whether the individual identified above is incapacitated according to the legal definition (on page 3), and whether that person should have a guardian appointed.

1. General Information

Physician's Name ____ Phone: (______)_________________

Office Address ____

____

☐ YES ☐ NO I am a physician currently licensed to practice in the State of Alabama.

Proposed Ward's Name ____

Date of Birth ____ Age_______ Gender ☐ M ☐ F

Proposed Ward's Current Residence: ____

I last examined the Proposed Ward on____, 20_____ at:_______.m

☐ Private Office ☐ a Medical facility ☐ Other:____

☐ YES ☐ NO The Proposed Ward is under my continuing treatment.

1. ☐ **YES** ☐ **NO** **Has one of the following objective measures of cognitive functioning been administered?**

☐ Mini Mental State Examination (MMSE)

i. The patient scored _____ out of a 30-point scale.

☐ Montreal Cognitive Assessment (MOCA)

i. The patient scored ___ out of a 30-point scale.

☐ Saint Louis University Mental Status (SLUMS) Examination

i. The patient scored _____ out of a 30-point scale.

☐ Neuropsychological or intelligence testing

What type of testing was conducted and what were the findings of the test?

2. Evaluation of the Proposed Ward's Physical Condition

Physical Diagnosis 1: ____

a. Severity: ☐ Mild ☐ Moderate ☐ Severe
b. Prognosis: ____
c. Treatment/Medical History:____

Physical Diagnosis 2: ____

a. Severity: ☐ Mild ☐ Moderate ☐ Severe
b. Prognosis: ____
c. Treatment/Medical History:____

Physical Diagnosis 3: ____

a. Severity: ☐ Mild ☐ Moderate ☐ Severe
b. Prognosis: ____
c. Treatment/Medical History:____

3. Evaluation of the Proposed Ward's Mental Functioning

Mental Diagnosis:____

a. Severity: ☐ Mild ☐ Moderate ☐ Severe
b. Prognosis:____
c. Treatment/Medical History:____

If the mental diagnosis includes dementia, answer the following:

☐ YES ☐ NO -----It would be in the Proposed Ward's best interest to be placed in a secured facility for the elderly or a secured nursing facility that specializes in the care and treatment of people with dementia.

d. Possibility for Improvement:

☐ YES ☐ NO -----Is **improvement in the Proposed Ward's physical condition and mental functioning possible?**

If "YES," after what period should the Proposed Ward be reevaluated to determine whether a guardianship continues to be necessary?____

4. <u>Cognitive Deficits</u>

a. The Proposed Ward <u>is oriented</u> to the following (check all that apply):

☐ Person ☐ Time ☐ Place ☐ Situation

b. The Proposed Ward <u>has a deficit</u> in the following areas (check all areas in which Proposed Ward has a deficit):

☐ ---Short-term memory
☐ ---Long-term memory
☐ ---Immediate recall
☐ ---Understanding and communicating (verbally or otherwise)
☐ ---Recognizing familiar objects and persons
☐ ---Solve problems
☐ ---Reasoning logically
☐ ---Grasping abstract aspects of his or her situation
☐ ---Interpreting idiomatic expressions or proverbs
☐ ---Breaking down complex tasks down into simple steps and carrying them out

c. ☐ YES ☐ NO --The Proposed Ward's periods of impairment from the deficits indicated above (if any) vary substantially in frequency, severity, or duration.

5. <u>Ability to Make Responsible Decisions</u>

Is the Proposed Ward <u>able to initiate and make responsible decisions</u> concerning himself or herself regarding the following:

☐ YES ☐ NO -----Make complex business, managerial, and financial decisions
☐ YES ☐ NO -----Manage a personal bank account
If "YES," should amount deposited in any such bank account be limited? ☐ YES ☐ NO
☐ YES ☐ NO -----Safely operate a motor vehicle
☐ YES ☐ NO -----Make decisions regarding marriage
☐ YES ☐ NO -----Determine the Proposed Ward's own residence
☐ YES ☐ NO -----Administer own medications on a daily basis
☐ YES ☐ NO -----Attend to basic activities of daily living (ADLs) (e.g., bathing, grooming, dressing, walking, toileting) without supports and services
☐ YES ☐ NO -----Attend to instrumental activities of daily living (e.g., shopping, cooking, traveling, cleaning)
☐ YES ☐ NO -----Consent to medical and dental treatment at this point going forward
☐ YES ☐ NO -----Consent to psychological and psychiatric treatment at this point going forward

6. <u>Developmental Disability</u>

☐ YES ☐ NO -----Does the Proposed Ward have developmental disability?
If "NO," skip to number 8 below.
If "YES," answer the following question <u>and</u> look at the next page.

Is the disability a result of the following? (Check all that apply)

☐ YES ☐ NO -----Intellectual Disability?
☐ YES ☐ NO -----Autism?
☐ YES ☐ NO -----Permanent Brain Damage?
☐ YES ☐ NO -----Cerebral Palsy?

☐ YES ☐ NO -----Down Syndrome?
☐ YES ☐ NO -----Other? Please explain ____

7. **Definition of Incapacity**

For purposes of this certificate of medical examination, the following definition of incapacity applies:

An "**Incapacitated Person**" is any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, physical or mental infirmities accompanying advanced age, chronic use of drugs, chronic intoxication, or other cause (except minority) to the extent of lacking sufficient understanding or capacity to make or communicate responsible decisions. Ala. Code 1975 § 26-2A-20

Evaluation of Capacity

☐ YES ☐ NO -----Based upon my last examination and observations of the Proposed Ward, it is my opinion that the Proposed Ward is incapacitated **according to the legal definition in** Ala. Code 1975 § 26-2A-20**, set out in the box above.**

If you indicated that the Proposed Ward is incapacitated, indicate the level of incapacity:

☐ **Total** -------------The Proposed Ward is totally without capacity (1) to care for himself or herself and (2) to manage his or her property.

☐ **Partial**------------The Proposed Ward lacks the capacity to do some, but not all, of the tasks necessary to care for himself or herself or to manage his or her property.

Evaluation of Capacity (continued)

If you indicated the Proposed Ward's incapacity is partial, what specific powers or duties do you believe the Ward is capable of performing independently?

If you answered "NO" to all of the questions regarding decision-making in Section 5 (on page 2) and yet still believe the Proposed Ward is **partially** incapacitated, please explain:

If you answered "YES" to any of the questions regarding decision-making in Section 5 (on page 2) and yet still believe the Proposed Ward is **totally** incapacitated, please explain:

What is the least restrictive placement that you consider is appropriate for the Proposed Ward:

☐ -----------Nursing home level of care ☐ -- Assisted Living Facility
☐ -----------Group Home ☐ -- Memory care unit
☐ -----------Own Home or with family ☐ -- Other ____

8. **Additional Information of Benefit to the Court:** If you have additional information concerning the Proposed Ward that you believe the Court should be aware of or other concerns about the Proposed Ward that are not included above, please explain on an additional page.

____ ________________________________
Physician's Signature Date

____
Physician's Name Printed