GUARDIANSHIP FORM A

STATE OF INDIANA)
) SS:
COUNTY OF MONROE)

IN THE MONROE CIRCUIT COURT

CAUSE NO. 53C01-_____

IN THE MATTER OF)
THE GUARDIANSHIP OF)
)
_____)

PHYSICIAN'S REPORT

1. General Information

Name _____

Phone (_____) _____

Office Address _____
_____

What is your License/Certification? _____

What is your area of specialty? _____

I last examined the Person on: _____, 20____

The Person is under my continuing treatment.
□ YES, since _____, 20____
□ NO

2. Evaluation of the Person's Physical Condition

Physical Diagnosis: _____
_____
_____

Severity: □ Mild □ Moderate □ Severe
Prognosis: □ Continuing □ Degenerative □ Recovering □ Relapsing

Treatment/Medical History/Additional Comments (attach additional pages, if necessary):
_____
_____ _____
_____ _____

3. Evaluation of the Person's Mental Functioning

The Person is oriented to the following (check all that apply):

□ Person □ Time □ Place □ Situation

Do you have concerns about the Person's functioning in the following areas? (check all that apply)

YES	NO	UNKNOWN	FUNCTION
			Short-term memory
			Long-term memory
			Immediate recall
			Understanding and communicating (verbally or otherwise)
			Recognizing familiar objects and persons
			Solving problems
			Reasoning logically
			Grasping abstract aspects of his or her situation
			Interpreting idiomatic expressions or proverbs
			Breaking down complex tasks into simple steps and carrying them out

Mental Diagnosis: _____

_____

Severity: □ Mild □ Moderate □ Severe

Prognosis: □ Continuing □ Degenerative □ Recovering □ Relapsing

Treatment/Medical History/Additional Comments:

_____

_____

4. Medication Information

□ YES □ NO Is the Person currently taking medication related to Person's physical or mental functioning as reported in sections 2 and 3? If "YES," please list:

_____

_____

Additional Comments: _____

_____

_____

_____

5. Decision-Making

Is the Person able to make decisions regarding the following?

YES	WITH SUPPORT	NO	UNKNOWN	ACTION/DECISION
				Make complex business, managerial, and/or financial decisions.
				Manage a personal bank account. If "YES," or "WITH SUPPORT," should amount deposited in any such bank account be limited? □ YES □ NO
				Pay his or her own bills.
				Safely operate a motor vehicle.
				Make decisions regarding marriage.
				Determine the Person's own residence.
				Live alone.
				Obtain food.
				Administer own medications daily.
				Attend to basic activities of daily living (ADLs) (e.g., bathing, grooming, dressing, walking, and/or toileting) with/out services.
				Attend to instrumental activities of daily living (e.g., shopping, cooking, traveling, and/or cleaning).
				Make appropriate judgments that will protect them personally, physically, and/or financially.
				Consent to medical and dental treatment.
				Consent to psychological and/or psychiatric treatment.

Additional Comments:

_____
_____
_____
_____
_____
_____

“Incapacitated person” means an individual who:
(1) cannot be located upon reasonable inquiry;
(2) is unable:
(A) to manage in whole or in part the individual's property;
(B) to provide self-care; **or**
(C) both;
because of insanity, mental illness, mental deficiency, physical illness, infirmity, habitual drunkenness, excessive use of drugs, incarceration, confinement, detention, duress, fraud, undue influence of others on the individual, or other incapacity; or
(3) has a developmental disability (as defined in IC § 12-7-2-61).

Ind. Code § 29-3-1-7.5

(a) **"Less restrictive alternatives"** means an approach to meeting a person's needs that restricts fewer rights of the person than would the appointment of the guardian.
(b) “**Less restrictive alternatives”** may include, but are not limited to, the following:
(1) A supported decision making agreement (as defined in IC § 29-3-14-2).
(2) Appropriate technological assistance.
(3) The appointment of a representative payee.
(4) The appointment of a health care representative (as defined in IC § 16-36-1-2).
(5) The creation of a power of attorney (as defined in IC § 30-5-2-7).

Ind. Code § 29-3-1-7.8

6. Evaluation of Less Restrictive Alternatives

According to the definition in Ind. Code § 29-3-1-7.8 and based upon your last examination and observations of the Person, in your opinion, the following less restrictive alternatives could be considered or implemented:

YES	NO	UN-KNOWN	LESS RESTRICTIVE ALTERNATIVE
			Supported decision making agreement
			Appropriate technological assistance
			Representative payee
			Health care representative
			Power of attorney
			Other_____

7. Evaluation of Capacity

According to the definition in Ind. Code § 29-3-1-7.5 and based upon your last examination and observations of the Person, in your opinion, the Person is:

□ Not incapacitated
□ Not incapacitated with use of the following less restrictive alternative:
_____
_____
_____
□ Partially incapacitated
□ Personal OR □ Financial
□ Totally incapacitated

Additional Comments:
_____
_____
_____
_____

8. Recommendation of Living Arrangement

In your opinion, what is the least restrictive living arrangement that you consider appropriate for the Person?

□ At home/at home with services
□ Community based residence
□ Facility based residence
□ Hospital based residence

Additional Comments:
_____
_____

9. Ability to Attend Court Hearing

□ YES There is no significant threat to the Person's health and/or safety that would prevent them from attending the court hearing.

□ NO There is a significant threat to the Person's health and/or safety that would prevent them from attending the court hearing.

10. Additional Information of Benefit to the Court

Please provide any additional information that would benefit the court (attach additional pages, if necessary).
_____
_____
_____

11. Additional Professional Evaluations

If the descriptions of the Person's condition or skills is based on evaluations or assistance by other professionals, please provide the names and contact information of those professionals who are able to provide additional information or evaluations.

Professional's Name_____ Phone (_____)_____

Office Address or E-mail _____

Professional's Name_____ Phone (_____) _____

Office Address or E-mail _____

I affirm under the penalties for perjury that the foregoing representations are true.

_____ _____

Signature Date

_____

Name Printed

_____