Name: ______________________________
Mailing Address: ______________________________
______________________________
Daytime Telephone ______________________________
Representing Self, Without a Lawyer

**IN THE SUPERIOR COURT OF ARIZONA,**
**YAVAPAI COUNTY**

In the Matter of the
☐ Guardianship ☐ Conservatorship of:

______________________________
☐ a Minor, ☐ an Adult.

**GC**______________________________

# EXAMINER REPORT TO COURT
**(AFTER HEARING)**

☐ **PHYSICIAN**
☐ **PSYCHOLOGIST**
☐ **REGISTERED NURSE**

| NOTICE TO EXAMINER: Because this information is confidential, this report will be purged from the court file, and will be kept confidential. It is only available for viewing by the Judge, and the appointed Guardian (and/or Conservator). |
|---|

Examiner:
Name______________________________
Address ______________________________
______________________________ Telephone ______________________________
What is your area of specialty? ______________________________
What is the date you last saw this patient? ______________________________
Is this person your patient? Yes ☐ No ☐

I was asked to do this evaluation because (check all that apply):

☐ I have been the alleged incapacitated person's physician for _____ years.

☐ I was asked to do so by the family.

☐ An attorney selected me.

☐ My officer is close to the incapacitated person's residence.

☐ I am the doctor for the incapacitated person's nursing home.

☐ Other: (List)

______________________________
______________________________
______________________________
______________________________

SPECIFIC DIAGNOSIS:

______________________________________________________________________________

______________________________________________________________________________

## PATIENT ASSESSMENT

Does the patient suffer from any functional impairments? Yes ☐ No ☐

PLEASE LIST IMPAIRMENTS: Include physical, mental or psychological

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

(attach additional sheets if more space is needed)

In your opinion, are these impairments permanent or temporary? ____________________________

If temporary, probable duration of impairment?_________________________________________

In your opinion, do the patient's impairments prevent the patient from receiving or evaluating information to make or communicate responsible decisions regarding him / herself? Yes ☐ No ☐

Please explain how the impairment prevents the patient from making or communicating responsible decisions about him / herself:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

What Activities of Daily Living (ADL's) can the patient perform with minimal or no direction?

______________________________________________________________________________

______________________________________________________________________________

Will the patient's ability to perform ADL's likely improve? Yes ☐ No ☐
If yes, probable time frame:_________________________________________

Do you believe that the person's condition could improve within 6 months to a year? Yes ☐ No ☐

Do you believe that any further medical evaluation or treatment would benefit the person?
Yes ☐ No ☐ Describe____________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

List current medications, dosage and effects of medications on patient:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

What is the prognosis for this patient?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Do you think there is any reason for the court to review this matter again within 6 months to a year?
Yes ☐ No ☐ If yes, please explain: ____________________________________________
______________________________________________________________________________

Please state your recommendation as the most appropriate rehabilitation or care plan:
(Nursing facility, therapy, return home with 24 hour care, etc.)

______________________________________________________________________________
______________________________________________________________________________

To your knowledge, does the patient have Health Care Directives? Yes ☐ No ☐
(Durable Medical Power of Attorney, Living Will, Pre-Hospital Directive)

Does the patient have a continued need of a guardian to make health care decisions? Yes ☐ No ☐

Other information:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Date______________________________ ______________________________________
Signature

______________________________________
Print name