Name: _____

Address: _____

_____

Daytime Telephone: _____

Representing Self, without a Lawyer

IN THE SUPERIOR COURT OF ARIZONA
YAVAPAI COUNTY

In the Matter of the Guardianship of:

_____
an Adult.

GC _____

EXAMINER
REPORT TO COURT
[ ] PHYSICIAN
[ ] PSYCHOLOGIST
[ ] REGISTERED NURSE

REQUIRED INFORMATION FROM EXAMINER:

1. INFORMATION ABOUT EXAMINER:

Name _____

Address _____

_____

Telephone _____

What is your area of specialty? _____

Are you Board certified in this area or any other? *(If so, please explain)*: _____

_____

What is the date you last saw this patient? _____

Is this person your patient? **Yes [ ] No [ ]**

How long have you been his or her physician? _____

Why were you asked to do this evaluation?

[ ] You have been the proposed Ward's physician for many years.
[ ] You were asked to do so by the family.
[ ] An attorney selected you.
[ ] You are the doctor for the proposed Ward's nursing home.
[ ] Other (please explain): _____

2. INFORMATION ABOUT PATIENT:

The patient suffers from a functional impairment. **Yes [ ] No [ ]**
(If yes, answer the following): **(ATTACH ADDITIONAL SHEETS IF MORE SPACE IS NEEDED)**

SPECIFIC DIAGNOSIS_____

IMPAIRMENTS *(Include physical, mental or psychological):*_____

ASSESSMENT OF PATIENT:

Has the proposed Ward been treated or hospitalized before for this difficulty? If so, when and where? _____

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/her? **Yes [ ] No [ ]**

Is the extent of the difficulty the proposed Ward is experiencing limiting the following abilities?

- [ ] To pay his or her bills
- [ ] To obtain food
- [ ] To provide adequate housing
- [ ] To perform daily self-help skills
- [ ] To live alone
- [ ] To take medication appropriately
- [ ] To make appropriate judgments that will protect him or her personally, physically, or financially

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:

Do you believe the medication is affecting the person's ability to ambulate?

Yes [ ] No [ ]

Do you believe that the medication is affecting the persons ability to respond coherently?
Yes [ ] No [ ]

Do you believe that a "medication holiday" would help you better evaluate this person?
Yes [ ] No [ ]

Do you believe that any changes made in the type or amount of medications the person is receiving would noticeably affect his or her mental or physical abilities? **Yes [ ] No [ ]**

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)

3. RECOMMENDATIONS:

Does the patient have a need of a guardian to make health care decisions? **Yes [ ] No [ ]**

DO YOU RECOMMEND A GUARDIAN BE APPOINTED? **Yes [ ] No [ ]**
If yes, do you recommend a limited or general guardianship? _____

DO YOU RECOMMEND A TEMPORARY GUARDIAN BE APPOINTED? **Yes [ ] No [ ]**
If yes, state what immediate injury or irreparable harm is likely to occur to this patient if a guardian is not immediately appointed:

_____

_____

_____

DO YOU BELIEVE THERE IS ANY REASON FOR THE COURT TO REVIEW THIS MATTER AGAIN WITHIN 6 MONTHS TO A YEAR? **Yes [ ] No [ ]**

Other information:

_____

_____

_____

_____

Date: _____

_____
Signature

_____
Print name