Name:____

Date of Birth:____

Is the person under my continued treatment? Yes No

If so for how long has treatment occurred?____

Last examined:____

Evaluation of physical condition

Diagnosis:____

Severity: Mild   Moderate   Severe

Prognosis: Continuing   Degenerative   Recovering   Relapsing/Remitting

Treatment/Medical History:

____

____

Evaluation of mental functioning

Oriented to:

Person   Place   Time   Situation   None

Do you have concerns about functioning in the following areas

Yes   No   Unknown

___ ___ ___ Short term memory

___ ___ ___ Long term memory

___ ___ ___ Immediate recall

___ ___ ___ Understanding and communicating (verbal or non-verbal)

___ ___ ___ Recognizing familiar objects and persons

___ ___ ___ Solving problems

___ ___ ___ Reasoning logically

___ ___ ___ Grasping abstract aspects of his or her situation

___ ___ ___ Interpreting expressions or proverbs

___ ___ ___ Breaking down complex tasks into simple steps and carrying them out

Mental Health Diagnosis: ____

Severity: Mild   Moderate   Severe

Prognosis: Continuing Degenerative Recovering Relapsing/Remitting

Treatment/Medical History:

____

____

Medication Information:

Is the person currently taking medication related to the person's physical or mental functioning as reported in sections 2 or 3, if yes, list:

____

____

Decision Making:

Is the person able to make decisions regarding the following:

Yes	With Support	No	Unknown	
___	_____________	___	___	Make complex business or financial decisions
___	_____________	___	___	Manage a person bank account-If with support should amount deposited be limited?
___	_____________	___	___	Pay own bills
___	_____________	___	___	Safely operate a motor vehicle
___	_____________	___	___	Make decisions regarding marriage or relationships
___	_____________	___	___	Determine place of residence
___	_____________	___	___	Live alone
___	_____________	___	___	Obtain food
___	_____________	___	___	Administer own medications daily
___	_____________	___	___	Basic ADLs (bathing, grooming, dressing, walking, toileting)
___	_____________	___	___	Instrumental ADLs (shopping, cooking, traveling, cleaning)
___	_____________	___	___	Make appropriate judgements to protect self physically, financially
___	_____________	___	___	Consent to medical/dental treatment
___	_____________	___	___	Consent to psychological/psychiatric treatment

Evaluation of Less Restrictive Alternatives:

According to IC 29-3-1-7.8 and based on last examination and observation of the person, in your opinion, can any of the following less restrictive alternatives be considered or implemented

Yes No Unknown

___ ___ ___ Supported decision making agreement

___ ___ ___ Appropriate technological assistance

___ ___ ___ Representative payee

___ ___ ___ Health care representative

___ ___ ___ Power of attorney

___ ___ ___ Other____

Evaluation of Capacity:

According to the definition in IC 29-3-1-7.5 and based on your last examination of the person, in your opinion, the person is:

___ Not incapacitated

___ Not incapacitated with use of less restrictive alternative

___ Partially incapacitated ___ Personal ___ Finacial

Additional Comments:

____
____
____

Recommendations of Living Arrangements:

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:

____
____
____

Ability to Attend Court Hearing:

YES NO There is a threat to the Persons's health and/or safety that would prevent them from attending the court hearing

Additional Information of Benefit to the Court:

Please provide any additional information that would benefit the court.

____
____
____

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

____
____

Professionals Name____ Phone_______________________

Offie Address or E-mail

____
____

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

____ ____________________________________

Signature Date

____

Name Printed

IC 29-3-1-7.5

"Incapacitated person" means in an individual who:

(1) Cannot be located upon reasonable inquiry;
(2) Is unable:
(A) To manage in whole or in part of 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)

IC 29-3-1-7.8

“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. Alternatives may include but ar enot limited to:

(1) A supported decision-making arrangement (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 (defined in IC 16-36-1-2)

(5) The creation of a power of attorney (defined in IC 30-5-2-7)