

## Examining Physician's or Psychologist's Report

### **INSTRUCTIONS**

**NOTE:** This report will be used in a legal proceeding to determine if this individual is in need of a guardian or in need of protective placement or protective services. Prior to examining this individual, you must inform the individual of his/her rights. Those rights are contained in the statement below and should be read by you to the individual before you begin your examination.

Please answer the questions to the best of your ability, to a reasonable degree of professional certainty. Any questions that you cannot answer should be marked "unknown." Type or print your answers neatly. You may supplement this report with attachments.

### **STATEMENT TO BE READ TO THE INDIVIDUAL PRIOR TO EXAMINATION**

I have been asked to give a professional opinion about your need for a guardian and for protective placement or protective services.

Before we begin, I must tell you:

- Things you say to me may be used to decide if you need a guardian.
- You have the right to refuse to participate in this evaluation, unless a court ordered you to participate.
- You have the right to refuse to speak with me.
- I am required to report to the Court even if you do not speak to me.
- What we discuss is not confidential and may be shared in Court.

### **DEFINITIONS**

**Developmentally Disabled:** A disability attributable to intellectual disability, cerebral palsy, epilepsy, autism, or another neurological condition closely related to intellectual disability or requiring treatment similar to that required for individuals with intellectual disability, which has continued or can be expected to continue indefinitely, substantially impairs an individual from adequately providing for his or her own care or custody, and constitutes a substantial handicap to the afflicted individual. The term does not include dementia that is primarily caused by degenerative brain disorder.

**Serious and Persistent Mental Illness:** A mental illness that is severe in degree and persistent in duration, that causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, that may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support that may be of lifelong duration. Serious and persistent mental illness includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include degenerative brain disorder or a primary diagnosis of a developmental disability or of alcohol or drug dependence.

**Degenerative Brain Disorder:** The loss or dysfunction of an individual's brain cells to the extent that he or she is substantially impaired in his or her ability to provide adequately for his or her own care or custody or to manage adequately his or her property or financial affairs.

**Other Like Incapacities:** Those conditions incurred at any age that are the result of accident, organic brain damage, mental or physical disability, or continued consumption or absorption of substances, and that produce a condition that substantially impairs an individual from providing for his or her own care or custody.

**Incapacity:** Inability to effectively receive and evaluate information or to make or communicate a decision with respect to the exercise of a right or power.

**Impairment:** Developmental disability, serious and persistent mental illness, degenerative brain disorder, or other like incapacities.

**Meet the Essential Requirements for Physical Health or Safety:** Perform those actions necessary to provide the health care, food, shelter, clothes, personal hygiene, and other care without which serious physical injury or illness will likely occur.

**Protective Services:** Services that when provided to an individual with developmental disabilities, degenerative brain disorder, serious and persistent mental illness, or other like incapacity, keep the individual safe from abuse, neglect, or misappropriation of property or prevent the individual from experiencing deterioration or from inflicting harm on himself/herself or another individual.

**(This Instruction Page should NOT be submitted to the Court)**

STATE OF WISCONSIN, CIRCUIT COURT, \_\_\_\_\_ COUNTY

IN THE MATTER OF

Amended

Name \_\_\_\_\_

**Examining Physician's or  
Psychologist's Report**

Date of Birth \_\_\_\_\_

Case No. \_\_\_\_\_

Prior to beginning your evaluation of this individual, did you read to him or her the "STATEMENT TO BE READ TO THE INDIVIDUAL PRIOR TO EXAMINATION?"  Yes  No

If no, Explain: \_\_\_\_\_

Did the individual appear to understand?  Yes  No

Comment: \_\_\_\_\_

**PATIENT INFORMATION:**

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Female  Male Marital Status: \_\_\_\_\_

If available: Height \_\_\_\_\_ Weight \_\_\_\_\_ Eyes \_\_\_\_\_ Hair Color \_\_\_\_\_

Children: \_\_\_\_\_

Educational Background: \_\_\_\_\_

Veteran Status: \_\_\_\_\_

Occupation and Employment Status: \_\_\_\_\_

**EXAMINATION**

Name of Examiner: \_\_\_\_\_

Date of Examination: \_\_\_\_\_ Time spent with the individual: \_\_\_\_\_

Place of Examination: \_\_\_\_\_

Collateral sources used as part of your evaluation

Records: \_\_\_\_\_

Interviews: \_\_\_\_\_

Other: \_\_\_\_\_

Brief History: (Report relevant social and medical history)

1. Check this box only if **ALL** of the following are true:
- A. This individual has suffered a sudden and catastrophic injury or illness and is presently unresponsive, unconscious, or comatose; AND
  - B. His or her condition is likely to persist for the foreseeable future; AND
  - C. It is not possible to interview or evaluate him or her, AND
  - D. An alternate decision maker is required to provide for his or her proper care and treatment.

(If #1. is checked, proceed directly to #9.)

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2. Did the individual's presentation suggest sedation, intoxication, delirium or other condition affecting the individual's participation in the examination?  Yes  No

Explain: \_\_\_\_\_

3. A. Estimate the individual's level of intelligence: \_\_\_\_\_

B. Describe the individual's level of functional knowledge: (e.g. ability to read, use currency, phone, etc.)  
\_\_\_\_\_

4. Note level of impairment and describe examination findings in the following areas:  
Orientation  Intact  Mild Impairment  Moderate  Severe

Findings: \_\_\_\_\_

Attention/Concentration  Intact  Mild Impairment  Moderate  Severe

Findings: \_\_\_\_\_

Sensory/Motor Functioning  Intact  Mild Impairment  Moderate  Severe

Findings: \_\_\_\_\_

Language/Communication  Intact  Mild Impairment  Moderate  Severe

Findings: \_\_\_\_\_

Memory  Intact  Mild Impairment  Moderate  Severe

Findings: \_\_\_\_\_

Reasoning  Intact  Mild Impairment  Moderate  Severe

Findings: \_\_\_\_\_

Other Executive Functioning  
(Insight, Judgment, Planning, Initiation, etc.)  Intact  Mild Impairment  Moderate  Severe

Findings: \_\_\_\_\_

Emotional/Behavioral Functioning  Intact  Mild Impairment  Moderate  Severe

Findings: \_\_\_\_\_

5. Does the individual adequately understand and appreciate the nature and consequences of any impairment he or she may have?  Yes  No  
Explain: \_\_\_\_\_

6. A. Does the individual have incapacity due to his/her impairments?  Yes  No

B. Is this incapacity permanent? (Unlikely to resolve with treatment)  Yes  No

C. Using the definitions on the instruction sheet, specify the condition(s) related to the incapacity.

- (Check all that apply)
- (1) Developmental disability.
  - (2) Degenerative brain disorder.
  - (3) Serious and persistent mental illness.
  - (4) Other like incapacities.

Is this condition likely to be permanent?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No

What are the diagnoses for each checkbox above?  
Explain: \_\_\_\_\_

7. Does the individual's incapacity interfere with ability to  
A. receive and evaluate information?  Yes  No

B. use information in a decision process?  Yes  No

C. communicate decisions?  Yes  No

D. protect himself or herself from abuse, exploitation, neglect or rights violation?  Yes  No

E. meet essential requirements of his or her health and safety?  Yes  No

F. manage his or her property and financial affairs?  Yes  No

G. address risk of property being dissipated in whole or in part?  Yes  No

H. provide for his or her own support?  Yes  No

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I. prevent financial exploitation?  Yes  No  
Explain how the individual's impairments result in the incapacities in A. – I. noted above:

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8. Would any of the following less restrictive interventions eliminate need for guardianship for this individual?
- A. Training or education  Yes  No
  - B. Support services  Yes  No
  - C. Assistive devices  Yes  No
  - D. Advanced planning (e.g. Powers of attorney, trust, etc.)  Yes  No
  - E. Representative payee  Yes  No
  - F. Other: \_\_\_\_\_  Yes  No
- Explain why a less restrictive measure is or is not appropriate for this individual:
- 

9. Does the individual have the evaluative capacity to
- A. execute a will?  Yes  No
  - B. serve on a jury?  Yes  No
  - C. register to vote or vote in an election?  Yes  No

10. A. Does the individual have the evaluative capacity to  
(If "No", indicate whether the individual could exercise the right with approval of his/her guardian.)
- (1) consent to marriage?  No  Yes  Yes, with guardian approval
  - (2) apply for an operator's/driver's license?  No  Yes  Yes, with guardian approval
  - (3) apply for a fishing license?  No  Yes  Yes, with guardian approval
  - (4) apply for a license under Ch. 29, Wis. Stats., other than fishing?  No  Yes  Yes, with guardian approval
  - (5) apply for any other license or credential under §54.25(2)(c)1.d., Wis. Stats. Specifically: \_\_\_\_\_  No  Yes  Yes, with guardian approval
  - (6) consent to sterilization?  No  Yes  Yes, with guardian approval
  - (7) consent to organ, tissue, or bone marrow donation?  No  Yes  Yes, with guardian approval

Comments: \_\_\_\_\_

- B. Does the individual have the evaluative capacity to
- (1)A consent to medical examination and treatment, and consent to voluntary medication, including psychotropic medication that is in the individual's best interests?  
 No  Yes, independently  Yes, with the following limitations: \_\_\_\_\_
  - (1)B consent to the involuntary administration of a medical examination, medication other than psychotropic medication, and medical treatment that is in the individual's best interests?  
 No  Yes, independently  Yes, with the following limitations: \_\_\_\_\_
  - (2) authorize the participation in an accredited or certified research project if the research project might help the individual or others, if there is a minimal risk of harm to the individual?  
 No  Yes, independently  Yes, with the following limitations: \_\_\_\_\_
  - (3) authorize the participation in research that might not help the individual but might help others if there is greater than minimal risk or harm to the individual, and evidence indicates the individual would have elected to participate?  
 No  Yes, independently  Yes, with the following limitations: \_\_\_\_\_
  - (4) consent to experimental treatment in the individual's best interests?  
 No  Yes, independently  Yes, with the following limitations: \_\_\_\_\_
  - (5) consent to receipt by individual of social and supported living services?  
 No  Yes, independently  Yes, with the following limitations: \_\_\_\_\_
  - (6) consent to release of confidential records other than court, treatment, and individual health care records and redisclosure as appropriate?  
 No  Yes, independently  Yes, with the following limitations: \_\_\_\_\_
  - (7) make decisions related to mobility and travel?  
 No  Yes, independently  Yes, with the following limitations: \_\_\_\_\_

### CONFIDENTIAL COURT FORM

- (8) choose providers of medical, social, and supported living services?  
 No  Yes, independently  Yes, with the following limitations: \_\_\_\_\_
- (9) make decisions regarding educational and vocational placement and support services or employment?  
 No  Yes, independently  Yes, with the following limitations: \_\_\_\_\_
- (10) make decisions regarding initiating a petition for termination of marriage?  
 No  Yes, independently  Yes, with the following limitations: \_\_\_\_\_

11. Is the individual prescribed psychotropic medications?  Yes  No  
 If Yes and the individual is refusing or resisting this course of treatment, do you recommend a full evaluation regarding capacity to refuse psychotropic medications?  Yes  No  
 Comments: \_\_\_\_\_

**PROTECTIVE PLACEMENT(#12 - #14)**

12. Does this individual require placement in a licensed, certified or registered setting?  Yes  No  
 A. If yes, does the individual have a primary need for residential care and custody?  Yes  No  
 B. If yes, does the individual's incapacity render him/her so incapable of providing for his/her own care or custody as to create a substantial risk of serious harm to himself/herself or others?  Yes  No  
 C. If yes, is the individual's incapacity permanent or likely to be permanent?  Yes  No

Explain: \_\_\_\_\_  
 If you answered "NO" to any part of #12, skip to #14.

13. Do the placement needs of this individual include: (Check all that apply)  
 24 hour supervision?  
 A secure setting with monitored egress?  
 A locked setting?  
 On site skilled nursing care?  
 Explain: \_\_\_\_\_

14. In lieu of protective placement for this individual, would you recommend protective services?  Yes  No  
 Specify: \_\_\_\_\_

15. Do you believe this individual is able to attend court hearings?  
 A. Yes.  
 B. There are medical contraindications to his or her attendance at a hearing. The individual could participate if the hearing was held at the individual's location.  
 C. There are other contraindications to the individual's attendance at a hearing.  
 Explain: \_\_\_\_\_

16. If you have any additional comments you feel are important in evaluating the individual's need for a guardianship and/or protective placement or services, make them here.  **See attached**  
 Comments: \_\_\_\_\_

**TO THE COURT:**

I am a  physician.  psychologist.

This report is made to the Court as part of a proceeding to appoint a guardian for an individual on the ground that the individual allegedly has incompetency. It contains my professional opinion regarding the presence and likely duration of any medical or other condition causing this individual to have incapacity.

I certify that I have, by personal examination and inquiry, satisfied myself as to the condition of capacity of this individual and the result of my evaluation and inquiry will be found in my answers to the above questions, which are true to the best of my knowledge and to a reasonable degree of professional certainty.

\_\_\_\_\_  
 Examiner  
 \_\_\_\_\_  
 Name Printed or Typed

\_\_\_\_\_  
 Address  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Date

**CONFIDENTIAL COURT FORM**