FOR CLERK'S USE ONLY

GUIDELINES FOR

HEALTH PROFESSIONAL'S REPORT

INSTRUCTIONS TO PETITIONER: Fill in the information below and give this document to the physician, registered nurse, or psychologist appointed by the Court to evaluate the health of the person said to need protection immediately after the "**ORDER APPOINTING** (Attorney, Health Professional, and Court Investigator)**"** is signed. The complete written report should be given to everyone listed in the "**ORDER APPOINTING"** no later than **10 days before** the scheduled hearing.

COURT CASE NUMBER: _____

NAME OF EVALUATOR: _____

_____

EVALUATOR'S PROFESSION: ☐ **Physician** ☐ **Registered Nurse** ☐ **Psychologist**

NAME OF PATIENT (subject of this evaluation)**:** _____
(Person said to need guardian)

NAME OF PETITIONER: _____

PETITIONER'S TELEPHONE NUMBER: _____

DATE AND TIME OF COURT HEARING: _____

INSTRUCTIONS TO PHYSICIAN OR OTHER EVALUATOR: A court case has been filed that asks the court to appoint a guardian for the person named as "Patient" above. Before granting such a petition, the court must decide if mental, physical, or other cause exists which requires appointment of a guardian. To make that decision, the Court needs to know what you think about:

- **the person's mental and physical health, and**
- **whether the person needs inpatient mental health treatment, and**
- **whether the person's driving privileges should be suspended.**

The court has developed this form to make it easier for you to prepare your report. You may submit your report using this form *or in any format you choose*, but please provide the same type of information as provided for on this form. Note that if the Petitioner is seeking authority to consent to inpatient mental health treatment this report or a separate report recommending such authority must be signed by a licensed psychologist or psychiatrist. (A.R.S. § 14-5303(C))

After you complete the report, give the original report to *the Petitioner,* who is responsible for distributing copies to the proper parties. Please do not file your report with the Clerk of the Court.

PLEASE DATE AND SIGN YOUR REPORT. The Court realizes that your time is valuable.

THANK YOU FOR YOUR TIME AND ASSISTANCE.

QUESTIONS FOR HEALTH PROFESSIONAL TO ANSWER:

Note: ***If not enough space*** on this form to answer, write in "See attached" and respond on separate page. Please re-state the question on the attachment and use same number as from this document.

1. What is the date you last saw the patient?
(Include date of this report if patient seen that date) _____

2. How long have you been treating the patient? _____

3. Why were you asked to do this evaluation?

- ☐ **I have been the person's physician for many years.**
- ☐ **I was asked to do so by the family.**
- ☐ **I was selected by an attorney.**
- ☐ **My office is close to the person's residence.**
- ☐ **I am a** ☐ **doctor,** ☐ **registered nurse, o r** ☐ **psychologist, for the person's nursing home.**
- ☐ **Other:** _____

4. What is your area of specialty? _____

Are you Board Certified in this area? ☐ **Yes** ☐ **No**
In any other areas? ☐ **Yes** ☐ **No**
If "yes", list: _____

5. Does the person you are evaluating appear to be having difficulty in any of the following areas?

- ☐ **Mental disorder**
- ☐ **Chronic intoxication or drug use**
- ☐ **Anything else (explain below)**
- ☐ **Physical illness**
- ☐ **Cognitive abilities**
- ☐ **Physical illness ONLY**

6. If he or she is having difficulty, please specify the nature of the illness, disorder, etc., including diagnosis:

_____
_____
_____
_____

7. Has the person been treated or hospitalized before for this difficulty? ☐ **Yes** ☐ **No**

If yes, when and where?

_____
_____
_____

8. **Is the person able to do the following things? Please check each applicable box.**

- ☐ **Pay his or her bills**
- ☐ **Obtain food**
- ☐ **Live alone**
- ☐ **Take medication appropriately**
- ☐ **Provide adequate housing**
- ☐ **Exercise daily self-help skills**
- ☐ **Make appropriate judgments that will protect him or her personally, physically, or financially**
- ☐ **Drive a motor vehicle.** (If "yes", explain below.)

If you believe a *guardianship* is warranted but you believe the person to be protected is capable of and *should be permitted to drive a motor vehicle*, please explain.

_____

_____

_____

9. **If the person is currently on medication, please list:**

_____

_____

_____

10. **Do you believe that the medication is affecting the person's ability to respond coherently?** ☐ **Yes** ☐ **No**

11. **Do you believe that the medication is affecting the person's ability to ambulate?** ☐ **Yes** ☐ **No**

12. **Do you believe that a "medication holiday," if possible, would help you better evaluate the person?** ☐ **Yes** ☐ **No**

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

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

If so, please give your recommendation:

_____

_____

_____

15. **Do you think the person would benefit from other types of therapy such as counseling?**

☐ **Yes** ☐ **No** **If yes, describe:**

_____

_____

_____

Case No. _____

16. Where do you think the person should live today?

- ☐ **At home with a companion**
- ☐ **At home with a nurse**
- ☐ **In a group home**
- ☐ **In a boarding home**
- ☐ **In a supervisory care facility**
- ☐ **In a nursing home**
- ☐ **In a hospital**
- ☐ **In an Inpatient Psychiatric Facility for inpatient mental health treatment. Explain.**
- ☐ ***Other* -- please explain.**

_____

_____

17. Do you believe that the person's condition could improve within 6 months to a year?

☐ **Yes** ☐ **No**

18. Is there is any reason for the court to review this matter again within less than one year?

☐ **Yes** ☐ **No**

19. Please make any additional comments or suggestions you think would be helpful to the court in making this decision.

_____

_____

_____

_____

MENTAL HEALTH TREATMENT ISSUES

(This section must be completed IF the petitioner is requesting authority for a *guardian* to consent to inpatient mental health treatment, *and if so*, this report or a separate report covering this information must be completed and signed by a licensed psychologist or psychiatrist.)

Note: *If not enough space* on this form to answer, write in "See attached" and respond on separate page. Please re-state the question on the attachment and use same number as from this document.

1. Is it the opinion of the undersigned that the patient is incapacitated as a result of a mental disorder?

☐ **Yes** ☐ **No**

2. What is the mental disorder? _____

_____

Case No. _____

3. **Is it the opinion of the undersigned that the patient is likely to need inpatient mental health care and treatment within the next year?** ☐ **Yes** ☐ **No** (The maximum term for which authority may be granted to place a patient in an Inpatient Psychiatric Facility and treatment is one year. This authority may be renewed or extended based on the evaluation and recommendation of a licensed physician or psychologist submitted with the annual report of the guardian**. A.R.S. § 14-5312.01(P)**)

4. **In the event that the answer to #3 is "Yes", please explain the need for, and the anticipated onset and duration of the inpatient treatment:**

_____

_____

_____

5. **What kind of treatment is the patient currently receiving for this disorder?**

_____

_____

_____

6. **Give a comprehensive assessment of any functional impairments of the patient.**

_____

_____

_____

7. **How and to what extent do these impairments affect the patient's ability to receive or evaluate information needed in making or communicating personal and financial decisions?**

_____

_____

8. **What tasks of daily living is the patient capable of performing without direction or with minimal direction?**

_____

_____

_____

9. **What is the most appropriate rehabilitation plan or care plan for the patient?**

_____

_____

_____

10. **What would be the least restrictive living arrangement reasonably available for the patient?**

_____

_____

_____

Case No. _____

11. Is there any reason why this patient should not personally appear in court? ☐ **Yes** ☐ **No**
If "yes", please explain.

_____

_____

_____

12. Please make any additional comments or suggestions you feel would be valuable to the court:

_____

_____

_____

_____

DATE REPORT PREPARED: _____

_____

SIGNATURE

_____

PRINTED NAME, PROFESSIONAL TITLE (MD, RN, etc.)