Area Five Agency on Aging & Community Services:
Adult Guardianship VASIA Program

PHYSICIAN'S REPORT

I,_____, a physician holding an unlimited
(Name of Physician)

License to practice medicine in the State of Indiana, do hereby submit the following report on _____, "Patient", based upon my professional examination of the Patient. Patient DOB:_____, Patient County of Residence:_____, Patient SS#:_____.

1. Dates of all examinations of the Patient within the last (3) months from the date hereof.

_____

_____

_____

_____

2. In your opinion, based upon your examination and observation of the patient, is the Patient incapacitated? If so, please describe the nature and type of incapacity.

_____

_____

_____

_____

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3. In your opinion, based upon your examination and observation of the Patient, how long has the Patient been incapacitated.

_____

_____

_____

_____

4. Describe the Patient's mental and physical condition; and, if appropriate, describe the Patient's educational condition, adaptive behavior and social skills.

_____

_____

_____

_____

5. In your opinion, is the Patient totally or partially incapable of making person and financial decisions; and, if the latter, please list the kinds of decisions which the Patient can and cannot make. Include the reason for this opinion.

_____

_____

_____

_____

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6. In your opinion, what is the most appropriate living arrangement for the Patient; and, if applicable, please describe the most appropriate treatment or rehabilitation plan. Include the reasons for your opinion.

_____

_____

_____

_____

7. Is the Patient able to appear in Court without injury to his/her mental/emotional/ physical health? Yes_____ No_____

If the answer is no, explain the medical reasons for your answer.

_____

_____

_____

_____

8. Is the Patient incapable of consenting to the appointment of a Guardian?
Yes_____ No_____

9. Is the nature of the Patient's incapacity such that it prevents the Patient from making a knowing and voluntary Waiver of Notice? Yes_____ No_____

10. In your opinion, is a Guardian needed to care for the Patient? Yes____ No____

If a Guardian is needed, is one needed for personal or financial needs, or both?

Personal____ Financial_____ Both_____

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I,_____, affirm under the penalties of perjury, that the
(Name)
above and foregoing is true and correct to the best of my knowledge and belief.

Signed_____

Name_____

Address_____

_____

Phone_____

Indiana Medical License No_____

Date_____

If the description of the Patient's mental, physical, and educational condition, adaptive behavior, or social skills is based on evaluations by other professionals, please provide the names and addresses of all professionals who are able to provide additional evaluations.

Evaluations on which the report is based must have been performed within three (3) months of the date of the filing of the Petition.

Names and addresses of other professionals who performed evaluations upon which this report is based follow below.

Name_____

Address_____

Phone_____

Name_____

Address_____

Phone_____

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Complete this document in its entirety and mail to:

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