MEDICAL CERTIFICATE GUARDIANSHIP OR CONSERVATORSHIP	Docket No.	Commonwealth of Massachusetts The Trial Court Probate and Family Court

INSTRUCTIONS FOR COMPLETION	Division
This document will be used by the Probate and Family Court in the process of determining whether to appoint a guardian and/or conservator to assume responsibility for this individual in some or all areas of decision making and functioning. If, however, a guardianship or conservatorship is being sought for a mentally retarded person, do not use this document. A separate Clinical Team Report is required.	

To the registered physician, licensed psychologist, or certified psychiatric nurse clinical specialist completing this document:

You must complete this document. If there is any information about which you do not have direct knowledge, you are encouraged to make inquiry of such other persons as may be necessary to complete the entire form. These persons might include other healthcare professionals and/or others acquainted with the individual (*e.g.*, family members or social service professionals). If you receive information from others, the names of those individuals must be listed in the Certification Section and attribution identified.

If you are completing this form on the computer and additional space is required for any narrative section, the section will expand to permit additional information. Do not use medical terminology and/or abbreviations without explaining them in terms that a lay person can understand.

ALL OF THE ATTACHED PAGES AND SECTIONS CONTAINED THEREIN MUST BE COMPLETED.

To the Honorable Justices of the Probate and Family Court:

The undersigned hereby certifies under the penalties of perjury that I am:

- ☐ a registered physician specializing in the area of: _____ .
- ☐ a licensed psychologist.
- ☐ a certified psychiatrist nurse clinical specialist.

I am prepared to present a statement of my qualification to the Court by written affidavit or personal appearance if directed to do so.

I personally examined: _____ (First Name) _____ (Middle Name) _____ (Last Name)

who resides at _____ (Address Line 1) _____ (Apt, Unit, No. etc.) _____ (City/Town) _____ (State) _____ (Zip)

on _____ (Date(s) of Examination(s))

Prior to examination, I informed the patient that communications would not be confidential.

- ☐ Yes.
- ☐ No, Explain:

_____

_____

_____

1. **CLINICALLY DIAGNOSE CONDITION(S) THAT RESULT IN INCAPACITY**

A. **Mental and physical condition**

Describe the individual's mental and physical conditions necessitating the appointment of a guardian and/or conservator, including the date of onset and disease course.

_____

_____

_____

B. **List all Medications (or attach list):**

Name	Dosage/Schedule

click to add

Could any of these medications impair mental functioning: ☐ Yes ☐ No ☐ Uncertain

If yes, explain:

_____

_____

_____

☐ Check if the individual is on any antipsychotic medications that require a Rogers treatment plan.

C. **Prognosis for Improvement**

If there are any aggravating factors that could make the individual appear confused but could improve with time or treatment (*e.g.,* delirium, acute medical illness, the interaction of multiple medications, hearing loss, vision loss, bereavement, etc.), describe these factors and explain how functioning might improve:

_____

_____

_____

With time and/or treatment, mental functioning could: ☐ Worsen ☐ Improve ☐ Stay the same

If improvement is possible, the individual should be re-evaluated in _____ weeks.

2. **INABILITY TO RECEIVE AND EVALUATE INFORMATION OR TO MAKE OR COMMUNICATE DECISIONS**

A. **Alertness/Level of Consciousness**

Overall Impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Non-Responsive

B. **Memory and Cognitive Functioning** (*e.g.*, memory, comprehension, reasoning, judgment, planning, insight)

Overall Impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe

C. **Emotional and Psychiatric Functioning** (*e.g.*, mood, anxiety, psychotic, substance use and other disorder)

Overall Impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Describe how impairments in A, B, and/or C cause the individual to have an inability to receive and evaluate information or make or communicate decisions:

_____

_____

_____

3.1 GUARDIANSHIP: INABILITY TO MEET ESSENTIAL REQUIREMENTS FOR PHYSICAL HEALTH, SAFETY, AND SELF-CARE

If seeking guardianship of the person, complete section 3.1. If seeking only a conservatorship, do not complete this section. Limited Guardianship is preferred by the court; describe how the guardianship may be limited. Describe how the assessment was performed and give specific examples.

A. **Areas in which the individual is able to meet the essential requirements for physical health, safety, and self-care:**

Describe the individual's retained abilities and adaptive behavior for physical health, safety, self-care for which the guardianship may be limited (*e.g.*, ability to manage ADL's and IADL's such as health, hygiene, home, communication, driving, leisure, social; functioning in the community; ability to express treatment choices and make medical decisions; ability to complete any or some legal transactions).

_____

_____

_____

B. **Areas in which the individual is unable to meet essential requirements for physical health, safety, or self-care:**
Describe the impairments in physical health, safety, and self-care for which the individual requires a guardian.

_____

_____

_____

C. **If individual is unable to make any decisions for him or herself or is unable to meet any essential requirements for physical health, safety, and self care (*i.e.* requires a full guardianship), describe why:**

_____

_____

_____

3.2 CONSERVATORSHIP: INABILITY TO MANAGE PROPERTY OR BUSINESS AFFAIRS EFFECTIVELY

Directions: If seeking conservatorship of the estate and affairs, complete section 3.2. If seeking only a guardianship of the person, do not complete this section. Limited Conservatorship is preferred by the court; describe how the conservatorship may be limited. Describe how the assessment was performed and give specific examples.

A. **Areas in which the individual is able to manage property or business affairs effectively:**

Describe the individual's retained abilities and adaptive behavior for management of property and estate for which the conservatorship may be limited (*e.g.*, ability to manage allowance, bills, donations, investments, real estate, protect assets, resist fraud).

_____

_____

_____

B. **Areas in which the individual is unable to manage property or business affairs effectively:**

Describe the impairments in the management of property and business affairs for which the individual requires a conservator. Describe how the person has property that will be wasted or dissipated unless management is provided and/ or how protection is necessary to provide money for the support, care and welfare of the person or those entitled to the person's support.

_____

_____

_____

C. **If the individual is unable to make any decisions about, and is unable to manage, any property or business affairs effectively (*i.e.* requires a full conservatorship), describe why:**

_____

_____

_____

4. **VALUES AND PREFERENCES**

Describe the individual's values, preferences, and patterns, including previously described preferences (*e.g.*, under durable power of attorney, advance directive, health care proxy, or living will documents), whether the individual accepts or opposes the guardianship/conservatorship, where the individual prefers to live, what makes life meaningful for the individual, and religious or cultural considerations.

_____

_____

_____

5. **SOCIAL NETWORKS AND RISK OF HARM TO SELF OR OTHERS**

A. **Social Network Relationships**

Social Support (Check one)

☐ Very good supportive network ☐ Some support from family and friends ☐ Limited or nonexistent support

Social Skills (Check one)

☐ Very good social skills ☐ Good social skills ☐ Poor social skills

B. **Nature of Risks.**

Describe the significant risks facing this individual and specify whether these risks are due to this individual's condition and/or due to another person harming or exploiting him or her:

_____

_____

_____

C. **The individual's risk of harm to self or others is:** ☐ Mild ☐ Moderate ☐ Severe

D. **The likelihood of harm is:** ☐ Almost Certain ☐ Probable ☐ Possible ☐ Unlikely

6. **RECOMMENDATIONS FOR LEVEL OF CARE/SUPERVISION NEEDED, INCLUDING HOUSING**

A. **An institutional placement being pursued at the following:**

☐ Nursing home/Rehabilitation ☐ Psychiatric facility ☐ Other facility ☐ None ☐ Uncertain

If none, skip to section 7; if yes, answer:

B. **The individual requires the following level of supervision:**

☐ Locked facility ☐ 24 hr. supervision ☐ Some ☐ None

Less restrictive placement options have been pursued:

☐ Yes ☐ No ☐ Uncertain

The placement is anticipated to be:

☐ Long-term ☐ Short-term ☐ Uncertain

Describe the specific reasons for placement and efforts made to preserve the person's social support system (*e.g.* placement in community of residence or near family):

_____

_____

_____

7. **RECOMMENDATIONS FOR APPROPRIATE TREATMENT AND HABILITATION:** The individual may benefit from:

Educational potential, training, or rehabilitation	☐ Yes	☐ No	☐ Uncertain
Technological assistance or accommodations	☐ Yes	☐ No	☐ Uncertain
Mental health treatment	☐ Yes	☐ No	☐ Uncertain
Occupational, physical, or other therapy	☐ Yes	☐ No	☐ Uncertain
Home and/or social services	☐ Yes	☐ No	☐ Uncertain
Medical treatment, operation or procedure	☐ Yes	☐ No	☐ Uncertain

Other: _____

Describe any specific recommendations:

_____

_____

_____

8. **ATTENDANCE AT HEARING**

☐ **It would be clinically harmful for the individual to attend the hearing. Describe why:**

_____

_____

_____

☐ **The individual is able to attend the court hearing**

What accommodations, if any, would enable the individual to attend the hearing:

_____

_____

_____

9. **CERTIFICATIONS**

This form was completed based on an in-person clinical evaluation of the individual:

who ☐ is ☐ is not a patient under my continuing care and treatment.

In addition to a clinical examination, other sources of information for this examination:

☐ Review of medical record.

☐ Discussion with health care professionals involved in the individual's care.

☐ Discussion with family or friends.

☐ Other _____

Names and titles of those individuals who assisted in preparation of this report:

Name	Title

click to add

List any tests which bear upon the issues of incapacity and date of tests:

Test	Date

click to add

This document must be signed and dated by the person completing it. It does not need to be notarized.

I hereby certify that the evaluation of diagnosis, cognition, and function is within the scope of my professional competence based upon my education, training, and experience. I further certify that this report is complete and accurate to the best of my information and belief.

Signed under the penalties of perjury:

_____ Date _____

SIGNATURE OF CLINICIAN

_____ _____

(Print name) License type, number, and date

Office Address: _____ _____ _____ _____ _____

(Address Line 1) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Office Phone: _____