ROGERS MONITOR SUPPLEMENTAL REPORT TO THE GUARDIAN'S CARE PLAN/REPORT	Docket No.	Commonwealth of Massachusetts The Trial Court Probate and Family Court

In the Interests of:

First Name _____ Middle Name _____ Last Name _____

Incapacitated Person

_____ **Division**

THIS FORM MAY ONLY BE USED BY A ROGERS MONITOR WHO IS ALSO THE GUARDIAN OF THE INCAPACITATED PERSON.

1. Please list the date on which you last reviewed the Incapacitated Person's medical records and current treatment plan, including the treating physician's treatment reports.

   Date: _____

2. The Incapacitated Person's current living circumstances are detailed in the attached Guardian's Care Plan/Report.

3. Were the physician's treatment reports complete and consistent with the Incapacitated Person's medical records?

   ☐ Yes ☐ No

   If **No**, please explain:

4. Please list the date when you last communicated with the treating physician.

   Date: _____

5. If you were unable to meet or speak with the treating physician in the last 6 months, please detail the attempts you made to contact the treating physician during that time period.

6. If you were unable to speak with the treating physician, did you review the physician's progress notes?

   ☐ Yes ☐ No

7. Please list other associated staff members with whom you have discussed the Incapacitated Person's current status and treatment needs.

Staff Member's Name	Title	Date(s) of Discussion	Length in Time of Discussion

click to add click to remove

8. Please describe the substance of the communications you had with the treating physician or associated staff members or information you gathered from reviewing the physician's progress notes regarding the Incapacitated Person's present status and the treatment needs with regard to the administration of antipsychotic medication.

9. What is the authorizing date and expiration date of the Court's last Order authorizing the administration of antipsychotic medication?

Date allowed: _____

Expiration Date: _____

10. Please list the current antipsychotic medications being administered to the Incapacitated Person and indicate any such anti-psychotic medication being administered which is not authorized by the Court's last order as a primary or alternate medication:

Medication	Dosage Range	Date Treatment Began	Authorized by Court's Last Order?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

click to add click to remove

11. Are the antipsychotic medications being administered consistent with the Incapacitated Person's medical needs?

☐ Yes ☐ No If **No**, please describe how they are not:

12. Since the Court's last order authorizing the administration of antipsychotic medication, has there been any change in the Incapacitated Person's capacity to make medical decisions, including treatment with antipsychotic medication?

☐ No ☐ Yes If **Yes**, please describe the change:

Date: _____

_____
SIGNATURE OF ROGERS MONITOR

_____
(Print Name)

_____
SIGNATURE OF CO-ROGERS MONITOR (if applicable)

_____
(Print Name)

Reset Form