

<b>MEDICAL CERTIFICATE GUARDIANSHIP OR CONSERVATORSHIP</b>	Docket No.	<b>Commonwealth of Massachusetts The Trial Court Probate and Family Court</b>
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<b><u>INSTRUCTIONS FOR COMPLETION</u></b>	<b>Division</b>
<p>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 an intellectually disabled person, do <u>not</u> use this document. A separate Clinical Team Report is required.</p>	<p>_____</p>

**To the registered physician, licensed psychologist, certified psychiatric nurse clinical specialist or a nurse practitioner 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 psychiatric nurse clinical specialist.
- a nurse practitioner with experience in the area of: \_\_\_\_\_ .

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
(age)

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 DIAGNOSED CONDITION(S) THAT RESULT IN INCAPACITY

A. Description of 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. Stability of mental and physical condition and living setting

I. In the past 90 days, has the individual's mental and/or physical condition changed?

Yes       No       Uncertain

If yes, please explain:

II. In the past 90 days, has the individual's living setting (i.e. community, hospital, nursing facility) changed?

Yes       No       Uncertain

If yes, please explain:

C. Prognosis for Improvement

With reasonable medical certainty, within the next 90 days, is the individual's mental and/or physical conditions likely to change substantially?

Yes       No       Uncertain

If yes, explain whether the condition is likely to worsen or improve, as well as 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.):

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

D. List all Medications (or attach list):

Name	Dosage/Schedule	If an anti-psychotic medication indicate with a checkmark.
		<input type="checkbox"/>

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

If yes, explain:

## 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

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/relationships of those individuals who assisted in preparation of this report:

Name	Title/Relationship

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

Test	Date

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:

\_\_\_\_\_  
SIGNATURE OF CLINICIAN

Date \_\_\_\_\_

\_\_\_\_\_  
(Print name)

\_\_\_\_\_  
License type, number, and date

Office Address: \_\_\_\_\_  
(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Office Phone: \_\_\_\_\_