REPORT OF MONITOR

Docket No.

Massachusetts Trial Court
Probate and Family Court

In the Interests of:

First Name _____ Middle Name _____ Last Name _____

Incapacitated Person

_____ **Division**

1. The Monitor of the Treatment Plan for the Incapacitated Person is:

First Name _____ M.I. _____ Last Name _____

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

Primary Phone #: _____ Email: _____

Relationship to Incapacitated Person _____

The Monitor was appointed on _____ (date) and ☐ is ☐ is not the Guardian.

The Monitor ☐ is ☐ is not the Conservator.

2. The Incapacitated Person currently lives at _____ (Address)

(Apt, Unit, No. etc.) _____ (City/Town) _____ (State) _____ (Zip) _____ which is a

☐ Community Residence ☐ DDS-operated Regional Center ☐ DMH Facility ☐ Nursing Facility ☐ Private Home

☐ Other: _____

3. The Monitor last met with the Incapacitated Person on _____ (date) .

The following was specifically discussed with the Incapacitated Person:

_____

_____

_____

4. The Monitor reviewed the Incapacitated Person's medical records, the Treatment Plan that was allowed by this Court on _____ (date) and other relevant information, on _____ (date)

The Incapacitated Person's treatment with antipsychotic medications ☐ is ☐ is not in compliance with the current Court Order.

If the treatment **is not** in compliance with the current Court Order, please explain the non-compliance:

_____

_____

_____

5. The Incapacitated Person is currently receiving the following antipsychotic medications:

List name(s) of antipsychotic medication(s) with dosage(s):

_____

_____

_____

6. The Monitor is in agreement with the clinician's opinion that the Incapacitated Person continues to be unable to make medical treatment decisions, and continues to need a court order for antipsychotic medication. The conditions and circumstances that necessitated the Court's present Order do not appear to have changed substantially.

7. The Monitor has discussed the Incapacitated Person's present status and treatment needs with the treating clinician.

☐ **Yes.** Specify what was discussed, whether in person or by telephone, and when.

☐ **No**. Explain on what date efforts were made to contact the clinician, in detail, and whether the clinician's progress notes were reviewed.

_____

_____

_____

8. The Monitor has spoken with the Incapacitated Person's Residential and/or Day program staff, if any, and with other treatment providers regarding the Incapacitated Person's present status and current treatment needs. Specifically, we have discussed the following (indicate with whom, whether in person or by telephone, and on what dates):

_____

_____

_____

I certify that a signed copy of this Report was provided to each of the following persons at least thirty (30) days prior to the expiration of the current Treatment Plan:

Name	Relationship	Address	Manner*	Date
	Counsel for the Incapacitated Person			
	Moving Party			

* Indicate if by hand delivery, first class mail, certified mail, or if by agreement, by e-mail or facsimile.

SIGNED UNDER THE PENALTIES OF PERJURY

I certify under the penalties of perjury that the foregoing statements are true to the best of my knowledge and belief.

Date _____

_____
Signature of Monitor

_____
Print full name

Primary Phone #: _____

Email: _____

Date _____

_____
Signature of Co-Monitor (if applicable)

_____
Print full name

Primary Phone #: _____

Email: _____