In Re

 NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: XXX-XX-\_\_\_\_\_

MEDICAL EVALUATION REPORT [64.2-2005]

TO: HEALTH PROFESSIONALS INVOLVED IN TREATMENT OF THE ABOVE:

The Circuit Court is being asked to consider appointment of a Guardian and or a Conservator of the above individual. Virginia law (64.2-2005) requires that the Court have a Medical Evaluation, and gives civil immunity for providing confidential patent information in good faith.

Please respond to the following questions regarding the medical condition of the above named patient. You may do so on this form or in a narrative on your letterhead which addresses the various questions. Responses should be legible and, where needed, give some detail in answer to the questions. Please **do not** use abbreviations or medical shorthand, as this form will be filed with the Court and considered as evidence. Use the back for additional comments if needed.

*This information will be kept confidential and will not be released o any third parties except as incident to a proceeding to appoint a guardian or conservator pursuant to Virginia law. See* ***HIPPA [45 CFR 164.512(e)]*** *for the authority of a covered entity to disclose protected health information without the written authorization of the affected individual.*

|  |
| --- |
| 1. State your full name,

Business address andOffice telephone number |
| 1. State you **Professional License,**

**Medical training** [School, degreeYear of graduation]:Any **specialty certifications**(“Boards”) you hold. |
| 1. **How long** have you known the

Patient? When did you **last** see the patient and obtain the information to  complete this evaluation?  |
| 1. What is/are the patient’s **diagnosis**?
 |
| 1. What **medication(s)** is the

patient receiving that **affect** the patient’s functioning?  |
| 1. (Circle One, please comment on amount of assistance needed if any)

Describe the **physical condition and functional impairment** of the patient, including:1. Describe the patient’s mobility: ambulatory cane walker wheelchair bedridden
2. Can the patient live independently? YES NO
3. Can the patient handle the following Activities of Daily Living Skills (ADLs) without assistance?
* Eating YES NO
* Dressing YES NO
* Bathing YES NO
* Other YES NO
 |
| 1. Considering the **Mental Condition and**

**Functional impairments** of the patient (Circle one: please explain negative answers)1. Is the patient **Aware of current**  Yes Moderately Somewhat No

**surroundings,** family and friends 1. Is the patient Aware of assets Yes Moderately Somewhat No

and liabilities 1. Is the patient **Alert**? Yes Moderately Somewhat No
2. Does the patient Have Evidence Yes Moderately Somewhat No

of diminished or limited mentalcapacity/ability(Please note any test results) |
| 1. In your **medical** Yes Moderately Somewhat No

**opinion/observation**, Can the patientmanage daily personal business affairs?  |
| 1. How likely will the condition of the patient Unlikely Doubtful Possible

improve? If improvement is likely, when canthe patient resume ADLs unassisted? Likely (When? ->) |
| 1. In your medical **opinion**, does the patient require someone to assist in
2. Personal Business affairs YES SOME NO
3. Activities of Daily Living Skills (ADLs) YES SOME NO
 |
| 1. How much can the patient participate in:
2. Personal Business Affairs FULLY SOME NOT-AT-ALL
3. Activities of Daily Living Skills (ADLs) FULLY SOME NOT –AT-ALL
 |
| 1. Have any **tests**  been conducted which

would indicate the patient’s mental or physical ability? If so, please summarizethe results. (use back if needed) |
| 1. Can (should) the patient: (Circle One)
* Drive (hold a Driver’s License)? YES NO
* Purchase, possess or transport YES NO

Firearms?* Sign/make a Power of Attorney or YES NO

Advance Medical Directive?* Prepare a Last Will and Testament? YES NO
* Vote? YES NO
 |
| 1. Please provide any further comments or information regarding this patient that may be useful to the Court in considering the appointment of a guardian or conservator. Use the back if needed.
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I certify that the diagnosis set forth in the Medical Evaluation Report, and the opinions expressed in this report, are offered to a reasonable degree of medical certainty.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_