Guardianship Referral

To: Harris County Probate Courts

Please note that this must accompany the original completed, notarized doctor's mental status exam. Complete the below and any additional information to the extent possible to the Harris County Probate Clerk's office at 201 Caroline, 8th Floor, Houston, Texas, 77002, 713-755-6425. (9/1/09 doctor's letter can be obtained at: http://www.hctx.net/probate/default.aspx).

Proposed Ward's Name (& AKA): ____

DOB: ________________________________ Admission date: ________________

Prior address: ____

Reason for referral of guardianship (brief summary of current situation): ____________

____

____

Attending doctor name and contact info: ________________________________

Social Worker's name and contact info: _________________________________

Financial Income Source(s) & Amounts:_______________________________

Claim #s for each income: ____

Family member or interested party names and contact info: ____________________

____

Advanced Directive Status: ________________ First language: ____________________

PHYSICIAN'S CERTIFICATE OF MEDICAL EXAMINATION

To Physician

The purpose of this form is to enable the Court to determine whether the individual identified above is incapacitated according to the legal definition and whether a guardian should be appointed to care for him or her.

Definition Of Incapacity

The following definition applies:

> An "**Incapacitated Person**" is "*an adult individual who, because of the physical or mental condition, is substantially unable to provide food, clothing, or shelter for himself or herself, to care for the individual's own health, or to manage the individual's own financial affairs.*" Texas Probate Code §601(14).

General Information

Physician's Name ____________________________ Phone (____) ________________________

Physician's Address ____

____

❒Yes ❒No I am a physician currently licensed to practice in the State of Texas.

Proposed Ward's Name ____

Date of Birth ____________________________ Age_________ Gender M / F

Primary Residence ____

Current Location of Ward (if different from Primary Residence): ______________________

____

I last examined the Proposed Ward on ________________________________, 20_______ at

❒ A Medical Facility ❒ The Proposed Ward's residence

❒ Other ____

❒ Yes ❒ No The Proposed Ward is under my continuing treatment.
I have treated the Proposed Ward since _________________, _____ (date).

❒ Yes ❒ No Before the examination, I informed the Proposed Ward that communication with me would not be privileged.

Evaluation of Capacity

1. Describe the nature, degree, and severity of incapacity, including functional deficits, if any, regarding the proposed ward:

2. Have temporary or reversible causes of mental impairment been evaluated and treated?

❒ Yes ❒ No ❒ Uncertain

3. With time and treatment, mental functioning will most likely:

❒ Improve ❒ Worsen ❒ Stay the Same

4. If the condition causing mental impairment is treatable or reversible, explain how functioning may improve. If there are mitigating factors such as hearing or vision loss that may cause the person to appear incapacitated describe these:

5. If improvement is possible, the individual should be re-evaluated in _______weeks.

Evaluation of Physical Condition and Mental Function

1. Provide your evaluation of the proposed ward's physical condition and mental function and summarize the proposed ward's medical history if reasonably available.

2. State how or in what manner the proposed ward's ability to make or communicate responsible decisions concerning himself or herself is affected by the physical or mental health.

3. Indicate whether the proposed ward is able to do the following:

❒ Yes ❒ No Understand or communicate
❒ Yes ❒ No Recognize familiar objects and individuals
❒ Yes ❒ No Perform simple calculations
❒ Yes ❒ No Break down complex tasks down into simple steps and carry them out
❒ Yes ❒ No Solve problems and reason logically
❒ Yes ❒ No Administer to basic activities of daily living (e.g. bathing, grooming, dressing, walking, toileting)
❒ independent ❒ needs assistance ❒ needs total care
❒ Yes ❒ No Vote in a public election
❒ Yes ❒ No Operate a motor vehicle safely
❒ Yes ❒ No Administer own medication on a daily basis
❒ Yes ❒ No Manage business affairs
❒ Yes ❒ No Manage financial matters
❒ Yes ❒ No Make personal decisions regarding residence
❒ Yes ❒ No Make decisions regarding marriage
❒ Yes ❒ No Consent to medical, dental, psychological, or psychiatric treatment

4. State whether any current medication affects the demeanor of the proposed ward or the proposed ward's ability to participate fully in a court proceeding. If so, provide the medication name and how it affects his/her demeanor or ability to participate in court proceedings.

Comments: ____

Mental Disability

1. ❒ Yes ❒ No Does the Proposed Ward have a developmental disorder?

   (A) If “Yes” above, is the disability a result of :

   ❒ Yes ❒ No Mental Retardation* (see boxed text, page 5)?
   ❒ Yes ❒ No Autism
   ❒ Yes ❒ No Other____

2. Describe the precise physical and mental disorders underlying the proposed ward’s incapacity, if any:

3. ❒ Yes ❒ No Would the proposed ward benefit from supports and services that would allow the individual to live in the least restrictive setting?

   Describe:

4. Level of care and/or supervision needed, including housing.
   ❒ secure facility ❒ 24hr supervision ❒ some supervision ❒ no supervision

5. If specific placement is recommended, please describe:

6. The individual would benefit from:

Education training	❒ 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
Assistive devices (e.g. hearing aid)	❒ Yes	❒ No	❒ Uncertain
Medical treatment	❒ Yes	❒ No	❒ Uncertain
Other	❒ Yes	❒ No	❒ Uncertain

   Describe:

IMPORTANT: If **mental retardation** is a basis for the Proposed Ward's incapacity, what is **your assessment** of the Proposed Ward's level of intellectual functioning?

❒ Mild (IQ of 50-55 to approximately 70)

❒ Moderate (IQ of 35-40 to 50-55)

❒ Severe (IQ of 20-25 to 35-40)

❒ Profound (IQ below 20-25)

❒ Yes ❒ No Is there evidence that the mental retardation originated during the Proposed Ward's developmental period?

Describe the Proposed Ward's adaptive behavior level:

I am: (check one or both if applicable):

❒ a physician or psychologist licensed in this state; or

❒ certified by the Department of Aging and Disability Services to perform the examination, in accordance with the rules of the executive commission of the Health and Human Services Commission governing such examinations

❒ Yes ❒ No The Determination of Mental Retardation was made in accordance with § 593.005, Health and Safety Code.

Evaluation of the Proposed Ward's Physical Condition and Mental Function

Physical Diagnosis: ______________________________

1. Prognosis: ______________________________
2. Severity: ❒Mild ❒Moderate ❒ Severe
3. Treatment: ______________________________

Mental Diagnosis: ______________________________

1. Prognosis: ______________________________
2. Severity: ❒Mild ❒Moderate ❒ Severe
3. Treatment: ______________________________
4. Please check all of the areas below in which the Proposed Ward has a deficit(s).
   ❒Short-term memory ❒Long-term memory ❒Immediate recall
5. ❒ Yes ❒ No Do the proposed ward's periods of impairment from the deficits indicated above (if any) vary substantially in frequency, severity, or duration?

Summary of Matters Related to the Proposed Ward's Property

In order to further assist the Court, please provide us with a summary of your findings by checking either "capable" or "incapable" for each topic below:

Capable	Incapable		
☐	☐	**a.**	to handle a bank account.
☐	☐	**b.**	to contract and incur obligations.
☐	☐	**c.**	to collect and file suit on debts, rentals, wages and other claims due.
☐	☐	**d.**	to pay, compromise and defend claims against him/herself.
☐	☐	**e.**	to apply for or consent to governmental services.
☐	☐	**f.**	to apply for and to receive funds from governmental sources.
☐	☐	**g.**	to enroll in public or private residential care facilities.
☐	☐	**h.**	to make employment decisions.
☐	☐	**i.**	to make decisions related to military service.
☐	☐	**j.**	to enter into insurance contracts of every nature.
☐	☐	**k.**	to operate a motor vehicle.
☐	☐	**l.**	to vote in an election.
☐	☐	**m.**	to participate in the selection of residential placement.
☐	☐	**n.**	to make residential placement decisions independently.
☐	☐	**o.**	to manage business affairs.
☐	☐	**p.**	to make financial decisions.
☐	☐	**q.**	to handle funds of $50.00 or less.
☐	☐	**r.**	to make decisions regarding marriage.
☐	☐	**s.**	Other: ____

Summary of Matters Related to the Proposed Ward's Person

Capable	Incapable		
☐	☐	**t.**	to apply for psychological and psychiatric tests and evaluations.
☐	☐	**u.**	to consent to medical and dental treatment and testing.
☐	☐	**v.**	to consent to disclosure of psychological and medical records.
☐	☐	**w.**	Other: ____

Ability to Attend Court Hearing

❒ Yes ❒ No The Proposed Ward would be able to attend, understand, and participate in a court hearing on an application for the appointment of a guardian.

❒ Yes ❒ No Because of his or her incapacities, the Proposed Ward's appearance at a Court hearing is not advisable because the Proposed Ward will not be able to understand or participate in the hearing.

It is my opinion that the Proposed Ward is:

_______ **totally without capacity.**

_______ **partially incapacitated.**

_______ **not incapacitated.**

I believe the Court should also be aware of the following additional information, if any, which concerns the Proposed Ward and which is not included above, but which may be of interest to the Court.

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Physician's Signature: ______________________________ Date: ____________________

Physician's Printed Name:____________________________ License No.:______________

PHYSICIAN'S AFFIDAVIT SUPPORTING MENTAL STATUS EXAM

STATE OF TEXAS §

COUNTY OF HARRIS §

On this day ______________________________, personally appeared before me the undersigned notary public, and after I administered an oath to him/her, upon his/her oath, stated as follows:

"I have personally examined ______________________________ and completed the mental status examination form. The facts in it are within my personal knowledge and are true and correct."

____
Signature

____
Printed Name

SWORN TO and SUBSCRIBED before me by _______________________________

on the ________ day of ____________________________, 20_______.

(seal)

____
Notary Public in and for
The State of Texas