

STATE OF INDIANA) IN THE MARION SUPERIOR COURT
) SS:
 COUNTY OF MARION) CAUSE NO. _____

IN THE MATTER OF THE GUARDIANSHIP OF)
)
 _____)

PHYSICIAN’S REPORT

Dr. _____, a physician licensed to practice medicine in all its branches in the State of Indiana, submits the following Report on _____, the alleged incapacitated person (“Person”) named above, based on an examination of said person conducted within the last three (3) months, on the ___ day of _____, 20___.

1. The nature and type of the Person’s disability or other incapacity is:

2. The Person’s mental and physical condition, and, when appropriate, their educational condition, adaptive behavior and social skills are:

3. In my opinion, the Person is [] totally or [] only partially incapable of making personal and financial decisions.

A. The kinds of decisions which the Person can and cannot make are:

B. The facts and/or reasons supporting this opinion are: _____

4. In my opinion, the most appropriate living arrangement for the Person is:

A. The most appropriate treatment or rehabilitation plan for the Person is:

B. The facts and / or reasons supporting this opinion are: _____

5. The Person [] can [] cannot appear in Court without creating a threat to his or her health or safety. Explain the specific risk to the Person's health or safety if he or she appears in Court.

The report must be signed by a physician. If the description of the Person's mental, physical and educational condition, adaptive behavior or social skills is based on evaluations by other professionals, all professionals preparing or contributing evaluations must sign the report. Evaluations on which the report is based must be performed within three (3) months of the date of the filing of the petition.

I/We affirm under the penalties of perjury that the foregoing representations are true.

Physician:

Name: Signature: _____
Street Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

Other professionals who performed evaluations upon which this report is based:

Name: Signature: _____
Profession: _____
Street Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

Other professionals who performed evaluations upon which this report is based:

Name: Signature: _____
Profession: _____
Street Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

Other professionals who performed evaluations upon which this report is based:

Name: Signature: _____
Profession: _____
Street Address: _____
City: _____ State: _____ Zip: _____ Phone: _____