DAVIS | AGNOR RAPAPORT | SKALNY Attorneys at Law

PHYSICIAN'S CERTIFICATE

NOTE TO PHYSICIAN: An individual will submit this document to a third party as good-faith evidence that a patient is legally incapacitated, for the purpose of taking over the financial affairs of the patient. Your answers must be specific and detailed and based on your personal examination of the patient. Address each issue contained in the certificate that may interfere with the patient's ability to make responsible decisions about the patient's property. You may complete the form yourself or have another person complete it under your supervision. Attach additional sheets, if necessary.

PATIENT'S NAME: _____

PATIENT'S ADDRESS: _____

I, _____ (Physician's Name),

_____ (Address),

_____ (Telephone Number), am a _____ (Year) graduate of _____

School of Medicine. I am licensed to practice medicine in the United States in the following state(s):

_____, My license number is: _____

I am board certified in _____. I have known this patient for _____ (Length of Time).

My history of involvement with the patient is as follows:

Examination and Diagnosis

I personally examined the above-named patient on _____ (Date(s)) (include date of most recent examination, as well as any other relevant visits). The most recent examination lasted approximately _____ (Time). I performed or ordered the following tests and/or procedures: _____

_____

_____

I communicated with the patient in the following manner:

☐ English

☐ Other language or means (explain):_____

Upon examination of the patient, I report the following findings:

PHYSICAL AND MENTAL CONDITIONS

Physical conditions

☐ None

☐ The patient has the following physical diagnoses:

_____

_____

Overall physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Explain:

_____

_____

Overall physical health will: ☐ Improve ☐ Be stable ☐ Decline ☐ Uncertain
Explain:

_____

_____

Mental conditions

☐ None

☐ The patient has the following mental (DSM) diagnoses:

Axis I.

_____

☐ Mild ☐ Moderate ☐ Severe

Axis II.

_____

☐ Mild ☐ Moderate ☐ Severe

Other:

_____

_____

☐ Mild ☐ Moderate ☐ Severe

Overall mental health will: ☐ Improve ☐ Be stable ☐ Decline ☐ Uncertain

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

The mental diagnosis/diagnoses affect functioning as follows:

_____

_____

_____

Have any temporary causes of mental impairment been evaluated and treated (e.g., depression, bereavement, or delirium)? ☐Yes ☐No ☐Uncertain

Explain:

Have any reversible causes of mental impairment been evaluated and treated (e.g., coma)?
☐ Yes ☐ No ☐ Uncertain

Explain:

List all medications:

Name	Purpose	Dosage/Schedule

Reversible or temporary somatic factors
Are there factors (e.g., hearing, vision or speech impairment, etc.) that incapacitate the patient that could improve with time, treatment, or assistive devices?
☐ Yes ☐ No ☐ Uncertain

Explain:

COGNITIVE FUNCTION

Alertness/level of consciousness
Overall impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Non-responsive
Describe below or ☐ in attachment

Memory, cognitive, and executive functioning
Overall impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Non-responsive
Describe below or ☐ in attachment

Fluctuation

Symptoms vary in frequency, severity, or duration: ☐ Yes ☐ No ☐ Uncertain

Describe below or ☐ in attachment

EVERYDAY FUNCTIONING

The patient **is capable** of performing the Instrumental Activities of Daily Living (IADLs) (select all that apply):

- ☐ Managing finances effectively
- ☐ Managing transportation needs
- ☐ Managing communication (e.g., telephone and mail)
- ☐ Other executive functions (describe):

The patient **is capable** of participating in the following civil or legal matters (select all that apply):

- ☐ Signing documents
- ☐ Retaining legal counsel
- ☐ Participating in legal proceedings
- ☐ Other (describe):

The patient ☐ **does** ☐ **does not** require institutional care.

Capacity to Make Responsible Decisions for Financial Matters

☐ In my professional opinion, within a reasonable degree of medical certainty, the patient has a disability which **(select one)** ☐ does ☐ does not prevent him/her from making or communicating **any** responsible decisions concerning his/her **property** and has a demonstrated inability to manage his/her **property** and affairs effectively because of physical or mental disability.

OR

☐ In my professional opinion, within a reasonable degree of medical certainty, the patient has a disability which **(select one)** ☐ does ☐ does not prevent him/her from making or communicating **some** responsible decisions concerning his/her **property**. The patient, for example, is able to make decisions regarding:

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but is unable to make decisions regarding:

I solemnly affirm under the penalties of perjury that the contents of this document are true to the best of my knowledge, information, and belief.

_____
Date

_____
Physician's Signature

_____
Printed Name