

# Physician's Certificate of Medical Examination

Revision September 2015

In the Matter of the Guardianship of \_\_\_\_\_,  
an Alleged Incapacitated Person

For Court Use Only  
Court Assigned: \_\_\_\_\_

## To the Physician

*This form is to enable the Court to determine whether the individual identified above is incapacitated according to the legal definition (on page 3), and whether that person should have a guardian appointed.*

### **1. General Information**

Physician's Name \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Office 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

Proposed Ward's Current 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.

YES  NO Before the examination, I informed the Proposed Ward that communications with me would not be privileged.

YES  NO A mini-mental status exam was given. If "YES," please attach a copy.

### **2. Evaluation of the Proposed Ward's Physical Condition**

Physical Diagnosis: \_\_\_\_\_

a. Severity:  Mild  Moderate  Severe

b. Prognosis: \_\_\_\_\_

c. Treatment/Medical History: \_\_\_\_\_

### **3. Evaluation of the Proposed Ward's Mental Functioning**

Mental Diagnosis: \_\_\_\_\_

a. Severity:  Mild  Moderate  Severe

b. Prognosis: \_\_\_\_\_

c. Treatment/Medical History: \_\_\_\_\_

If the mental diagnosis includes dementia, answer the following:

YES  NO ---- It would be in the Proposed Ward's best interest to be placed in a secured facility for the elderly or a secured nursing facility that specializes in the care and treatment of people with dementia.

YES  NO ---- It would be in the Proposed Ward's best interest to be administered medications appropriate for the care and treatment of dementia.

YES  NO ---- The Proposed Ward currently has sufficient capacity to give informed consent to the administration of dementia medications.

d. Possibility for Improvement:

YES  NO ---- **Is improvement in the Proposed Ward's physical condition and mental functioning possible?**

If "YES," after what period should the Proposed Ward be reevaluated to determine whether a guardianship continues to be necessary? \_\_\_\_\_

#### 4. Cognitive Deficits

- a. The Proposed Ward is oriented to the following (check all that apply):  
 Person    Time    Place    Situation
- b. The Proposed Ward has a deficit in the following areas (check all areas in which Proposed Ward has a deficit):  
 --- Short-term memory  
 --- Long-term memory  
 --- Immediate recall  
 --- Understanding and communicating (verbally or otherwise)  
 --- Recognizing familiar objects and persons  
 --- Solve problems  
 --- Reasoning logically  
 --- Grasping abstract aspects of his or her situation  
 --- Interpreting idiomatic expressions or proverbs  
 --- Breaking down complex tasks down into simple steps and carrying them out
- c.  YES    NO -- The Proposed Ward's periods of impairment from the deficits indicated above (if any) vary substantially in frequency, severity, or duration.

#### 5. Ability to Make Responsible Decisions

Is the Proposed Ward able to initiate and make responsible decisions concerning himself or herself regarding the following:

- YES    NO ---- Make complex business, managerial, and financial decisions  
 YES    NO ---- Manage a personal bank account  
    If "YES," should amount deposited in any such bank account be limited?    YES    NO  
 YES    NO ---- Safely operate a motor vehicle  
 YES    NO ---- Vote in a public election  
 YES    NO ---- Make decisions regarding marriage  
 YES    NO ---- Determine the Proposed Ward's own residence  
 YES    NO ---- Administer own medications on a daily basis  
 YES    NO ---- Attend to basic activities of daily living (ADLs) (e.g., bathing, grooming, dressing, walking, toileting) without supports and services  
 YES    NO ---- Attend to basic activities of daily living (ADLs) (e.g., bathing, grooming, dressing, walking, toileting) with supports and services  
 YES    NO ---- Attend to instrumental activities of daily living (e.g., shopping, cooking, traveling, cleaning)  
 YES    NO ---- Consent to medical and dental treatment at this point going forward  
 YES    NO ---- Consent to psychological and psychiatric treatment at this point going forward

#### 6. Developmental Disability

- YES    NO ---- Does the Proposed Ward have developmental disability?  
    If "NO," skip to number 7 below.  
    If "YES," answer the following question and look at the next page.

Is the disability a result of the following? (Check all that apply)

- YES    NO ---- Intellectual Disability?  
 YES    NO ---- Autism?  
 YES    NO ---- Static Encephalopathy?  
 YES    NO ---- Cerebral Palsy?  
 YES    NO ---- Down Syndrome?  
 YES    NO ---- Other? Please explain \_\_\_\_\_

Answer the questions in the "Determination of Intellectual Disability" box below only if both of the following are true:

- (1) The basis of a proposed ward's alleged incapacity is intellectual disability.  
**and**

(2) **You are making a “Determination of Intellectual Disability” in accordance with rules of the executive commissioner of the Health and Human Services Commission governing examinations of that kind.**

If you are not making such a determination, please skip to number 7 below.

**“DETERMINATION OF INTELLECTUAL DISABILITY”**

Among other requirements, a Determination of Intellectual Disability must be based on an interview with the Proposed Ward and on a professional assessment that includes the following:

- 1) a measure of the Proposed Ward’s intellectual functioning;
- 2) a determination of the Proposed Ward’s adaptive behavior level; and
- 3) evidence of origination during the Proposed Ward’s developmental period.

*As a physician, you may use a previous assessment, social history, or relevant record from a school district, another physician, a psychologist, an authorized provider, a public agency, or a private agency if you determine that the previous assessment, social history, or record is valid.*

- 1. Check the appropriate statement below. If neither statement is true, skip to number 7 below.
  - I examined the proposed ward in accordance with rules of the executive commissioner of the Health and Human Services Commission governing Intellectual Disability examinations**, and my written findings and recommendations include a determination of an intellectual disability.
  - I am updating or endorsing in writing a prior determination of an intellectual disability** for the proposed ward made in accordance with rules of the executive commissioner of the Health and Human Services Commission by a physician or psychologist licensed in this state or an authorized provider certified by the Department of Aging and Disability Services to perform the examination.
- 2. What is your assessment of the Proposed Ward’s level of intellectual functioning and adaptive behavior?
  - Mild (IQ of 50-55 to approx. 70)                       Moderate (IQ of 35-40 to 50-55)
  - Severe (IQ of 20-25 to 35-40)                       Profound (IQ below 20-25)
- 3.  Yes     No ---- Is there evidence that the intellectual disability originated during the Proposed Ward’s developmental period?

**Note to attorneys:** *If the above box is filled out because a determination of intellectual disability has been made in accordance with rules of the executive commissioner of the Health and Human Services Commission governing examinations of that kind, a Court may grant a guardianship application if (1) the examination is made not earlier than 24 months before the date of the hearing or (2) a prior determination of an intellectual disability was updated or endorsed in writing not earlier than 24 months before the hearing date. If a physician’s diagnosis of intellectual disability is not made in accordance with rules of the executive commissioner — and the above box is not filled out — the court may grant a guardianship application only if the Physician’s Certificate of Medical Examination is based on an examination the physician performed within 120 days of the date the application for guardianship was filed. See Texas Estates Code § 1101.104(1).*

**7. Definition of Incapacity**

**For purposes of this certificate of medical examination, the following definition of incapacity applies:**

An “**Incapacitated Person**” is an adult who, because of a physical or mental condition, is substantially unable to:  
(a) provide food, clothing, or shelter for himself or herself; (b) care for the person’s own physical health; or  
(c) manage the person’s own financial affairs. Texas Estates Code § 1002.017.

**8. Evaluation of Capacity**

- YES     NO ---- Based upon my last examination and observations of the Proposed Ward, it is my opinion that the Proposed Ward is incapacitated **according to the legal definition in section 1002.017 of the Texas Estates Code, set out in the box above.**

If you indicated that the Proposed Ward is incapacitated, indicate the level of incapacity:

- Total** ----- The Proposed Ward is totally without capacity (1) to care for himself or herself and (2) to manage his or her property.
- Partial** ----- The Proposed Ward lacks the capacity to do some, but not all, of the tasks necessary to care for himself or herself or to manage his or her property.

**Evaluation of Capacity (continued)**

If you indicated the Proposed Ward’s incapacity is partial, what specific powers or duties of the guardian should be limited if the Proposed Ward receives supports and services? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you answered “NO” to all of the questions regarding decision-making in Section 5 (on page 2) and yet still believe the Proposed Ward is **partially** incapacitated, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you answered “YES” to any of the questions regarding decision-making in Section 5 (on page 2) and yet still believe the Proposed Ward is **totally** incapacitated, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**9. Ability to Attend Court Hearing**

- YES  NO ---- The Proposed Ward would be able to attend, understand, and participate in the hearing.
- YES  NO ---- Because of the Proposed Ward’s incapacities, I recommend that the Proposed Ward not appear at a Court hearing.
- YES  NO ---- Does any current medication taken by the Proposed Ward affect the demeanor of the Proposed Ward or his or her ability to participate fully in a court proceeding?

**10. What is the least restrictive placement that you consider is appropriate for the Proposed Ward:**

- Nursing home level of care       --- Assisted Living Facility
- Group Home                               --- Memory care unit
- Own Home or with family       --- Other \_\_\_\_\_

**11. Additional Information of Benefit to the Court:** If you have additional information concerning the Proposed Ward that you believe the Court should be aware of or other concerns about the Proposed Ward that are not included above, please explain on an additional page.

\_\_\_\_\_  
Physician’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician’s Name Printed

\_\_\_\_\_  
License Number

*Revised September 2015*