

MEDICAL AFFIDAVIT

Please complete this form to the best of your knowledge and ability.

Today's Date:	Referring Court:		
EXAMINER INFORMATION			
Examiner's Last Name:	First:	Middle:	Specialty:
Hospital / Medical Group Affiliation:		Years Practicing:	State of Licensure:
Address:		Designation: M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A. <input type="checkbox"/> Ph.D. <input type="checkbox"/>	

§ 305 & 407

Professional evaluation

The chancery court must conduct a hearing to determine whether a guardian/conservator is needed for the respondent. Before the hearing, the court, in its discretion, may appoint a guardian ad litem to look after the interest of the person in question; the guardian ad litem must be present at the hearing and present the interests of the respondent.

The chancery judge shall be the judge of the number and character of the witnesses and proof to be presented, except that the proof must include certificates made after a personal examination of the respondent by the following professionals, each of whom shall make in writing a certificate of the results of that examination to be filed with the clerk of the court and become a part of the record of the case, two (2) licensed physicians; or one (1) licensed physician and either one (1) licensed psychologist, nurse practitioner, or physician's assistant.

The personal examination may occur face-to-face or via telemedicine, but any telemedicine examination must be made using an audio-visual connection by a physician licensed in this state and as defined in Section 83-9-351. A nurse practitioner or physician assistant conducting an examination shall not also be in a collaborative or supervisory relationship, as the law may otherwise require, with the physician conducting the examination. A professional conducting an examination under this section may also be called to testify at the hearing.

§ 301

Basis for appointment of guardian

The court may appoint a guardian for an adult when the respondent lacks the ability to meet essential requirements for physical health, safety or self-care because the adult is unable to receive and evaluate information or make or communicate decisions, even with appropriate supportive services or technological assistance; or the adult is found to be a person with mental illness or a person with an intellectual disability as defined in Section 41-21-61 who is also incapable of taking care of his or her person.

§ 401

Basis for appointment of conservator

The court may appoint a conservator for the property or financial affairs of an adult if the court finds by clear and convincing evidence that the adult is unable to manage property or financial affairs because of a limitation in the adult's ability to receive and evaluate information or make or communicate decisions, even with the use of appropriate supportive services or technological assistance; the adult is missing, detained, incarcerated, or unable to return to the United States.

<i>Signature</i>	
<i>Date</i>	

PATIENT INFORMATION					
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Patient's Last Name:	First:	M:	Marital Status:		
Is this the patient's legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is his / her legal name?	Former name:	Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Address:					

Have you treated this patient in the past for his / her medical needs, whether related or unrelated to this exam?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate the dates and circumstances within the last year, and / or reference if you have been the patient's personal physician for a period of time and the time frame:	
Did a friend or family member accompany the patient during your examination?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name / Relationship to Patient: Phone Number:	Is this the patient's primary caretaker? <input type="checkbox"/> Yes <input type="checkbox"/> No

If the above named individual is not the patient's primary caretaker, who is? (Name / Phone / Relationship to Patient):

EVALUATION

MEDICAL HISTORY – Physical	Has the patient experienced	Physical Impairments or Chronic Pain:	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		
		Chronic Diseases or Illnesses:	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		
		Surgery within the past year	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		
	Are there any physical limitations affecting the patient's	Activities of Daily Living	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		
		Cognitive / Memory Abilities	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		
	In the last six months, has the patient had:	Hospitalizations	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		
		Therapy or Treatment	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		
		Psychological or Psychiatric Testing	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		
	Patient's Current Condition / Status of Physical Illnesses:				
	History of Substance Abuse / Use		<input type="checkbox"/> Denies Substance Use <input type="checkbox"/> Prescribed Medications Only		
Drug(s) of Choice and Age of Onset:		Has the Patient Previously Sought Addiction Treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Patterns of Substance Use / Abuse	How Much:	How Often:			
	Methods of Use: <input type="checkbox"/> Oral <input type="checkbox"/> Snort <input type="checkbox"/> Inject <input type="checkbox"/> Insert <input type="checkbox"/> Inhale <input type="checkbox"/> Other: _____				

MEDICAL HISTORY – Mental	Previous Psychiatric Issues:			
	Do these psychiatric / mental illnesses affect the patient's ability to take care of him / herself?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does the patient suffer from a developmental and / or intellectual disability?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Previous In-Patient or Out-Patient Psychiatric Treatment (with dates and location):			
	Does the Patient Indicate Homicidal Ideation or Behavior?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the Patient Indicate Suicidal Ideation or Behavior?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Describe Other Counseling and / or Therapeutic Experiences:			
	Set forth the results of any tests which bear on the issue of incapacity and date of test (attach results if necessary):			
	Traumatic Event Exposure / History (Where applicable, identify type and date of event): <input type="checkbox"/> Serious Accidents: _____ <input type="checkbox"/> Natural Disaster: _____ <input type="checkbox"/> Witness to Traumatic Event: _____ <input type="checkbox"/> Sexual Assault: _____ <input type="checkbox"/> Physical Assault: _____ <input type="checkbox"/> Childhood Molestation: _____ <input type="checkbox"/> Close Family / Friend Murdered: _____ <input type="checkbox"/> Homelessness: _____ <input type="checkbox"/> Victim of Stalking / Bullying: _____ <input type="checkbox"/> N / A <input type="checkbox"/> Other (Specify): _____ _____ _____		Social / Cultural History (Note / Describe Relationships as Appropriate): Parents: <input type="checkbox"/> Close <input type="checkbox"/> Amicable <input type="checkbox"/> Estranged <input type="checkbox"/> Other: _____ Spouse / Partner: <input type="checkbox"/> Close <input type="checkbox"/> Amicable <input type="checkbox"/> Estranged <input type="checkbox"/> Other: _____ Children: <input type="checkbox"/> Close <input type="checkbox"/> Amicable <input type="checkbox"/> Estranged <input type="checkbox"/> Other: _____ Siblings: <input type="checkbox"/> Close <input type="checkbox"/> Amicable <input type="checkbox"/> Estranged <input type="checkbox"/> Other: _____ Other Family: <input type="checkbox"/> Close <input type="checkbox"/> Amicable <input type="checkbox"/> Estranged <input type="checkbox"/> Other: _____ Friends / Colleagues: <input type="checkbox"/> Close <input type="checkbox"/> Amicable <input type="checkbox"/> Estranged <input type="checkbox"/> Other: _____	

Indication of Functional Limitations (Check Major Life Areas Affected)	<input type="checkbox"/> Basic Living Skills (eating, bathing, dressing, etc.)	
	<input type="checkbox"/> Instrumental Living Skills (maintaining a home, managing money, local travel, taking medications, etc.)	
	<input type="checkbox"/> Social Functioning (ability to function within the family, vocational or educational settings, other social contexts)	
Does the patient have the mental or physical capacity to effectively manage his / her property?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined
Does the patient have the mental or physical capacity to make necessary daily living and health care decisions?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined
Initial Behavioral Observations	Speech	<input type="checkbox"/> Appropriate <input type="checkbox"/> Slowed <input type="checkbox"/> Mechanical <input type="checkbox"/> Rapid <input type="checkbox"/> Other: _____
	Behavior	<input type="checkbox"/> Appropriate <input type="checkbox"/> Withdrawn <input type="checkbox"/> Bizarre <input type="checkbox"/> Volatile <input type="checkbox"/> Other: _____
	Appearance	<input type="checkbox"/> Appropriate <input type="checkbox"/> Disheveled <input type="checkbox"/> Unclean <input type="checkbox"/> Inappropriately Dressed <input type="checkbox"/> Other: _____
	Mood	<input type="checkbox"/> Appropriate <input type="checkbox"/> Manic <input type="checkbox"/> Depressed <input type="checkbox"/> Labile <input type="checkbox"/> Irritable <input type="checkbox"/> Other: _____
	Affect	<input type="checkbox"/> Appropriate <input type="checkbox"/> Flat <input type="checkbox"/> Labile <input type="checkbox"/> Other: _____
	Oriented To	<input type="checkbox"/> Place <input type="checkbox"/> Time <input type="checkbox"/> Person <input type="checkbox"/> Situation <input type="checkbox"/> Other: _____
	Thought Content	<input type="checkbox"/> Appropriate <input type="checkbox"/> Incoherent <input type="checkbox"/> Obsessive <input type="checkbox"/> Other: _____
	Memory	<input type="checkbox"/> Appropriate <input type="checkbox"/> Repressed <input type="checkbox"/> Confused <input type="checkbox"/> Other: _____
	Judgment / Insight	<input type="checkbox"/> Appropriate <input type="checkbox"/> Impaired <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Other: _____
Comments on Mental / Physical Health:		
SUMMARY / RECOMMENDATION		
This Evaluation was Conducted (Check all that Apply):	<input type="checkbox"/> In Person <input type="checkbox"/> Via Audiovisual Telemedicine <input type="checkbox"/> At Hospital / Medical Office <input type="checkbox"/> At the Patient's Residence	
	<input type="checkbox"/> Other: _____	
	If via Telemedicine, who assisted you with the evaluation? (Name, Designation)	Your Mississippi License Number:
Diagnosis	Did you perform a physical exam on the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did any concerns result from the physical exam? <input type="checkbox"/> Yes: _____ <input type="checkbox"/> No <input type="checkbox"/> N/A
	Based on the foregoing evaluation:	<input checked="" type="checkbox"/> I DO <input type="checkbox"/> I DO NOT believe this patient is a person incapable of managing his / her own person under Section 301 or financial affairs under Section 401, and is in need of a Guardian and / or Conservator (check all that apply): <input type="checkbox"/> Guardian (Person) <input type="checkbox"/> Conservator (Financial Affairs) <input type="checkbox"/> Both
		I find that the patient is in need of treatment <input type="checkbox"/> Temporarily <input type="checkbox"/> Permanently <input type="checkbox"/> Other: _____
	I recommend the Court require re-evaluation in:	<input type="checkbox"/> 60 days <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____
Summary of Diagnosis:		

I, _____, the above named examiner, certify that this patient's **examination** was completed on (date) _____ at (time) _____, and that this **evaluation** and **recommendation** was completed on (date) _____ at (time) _____.

I hereby certify that that the facts stated above, and the information contained in this report, are true to the best of my knowledge and belief.

SWORN to before me this _____ day of _____,

Signature

Printed Name

Date

Notary Public for the County of _____

in the state of _____