PHYSICIAN'S REPORT OF INCAPACITATION

When completed, please return to:
EUREKA COUNTY PUBLIC GUARDIAN
10 South Main Street
PO BOX 506
Eureka, Nevada 89316
Fax (775) 237-6015
Telephone (775) 237-5664

Re:_____ Date of Birth / ____/_____
(Name)

I am a medical doctor licensed to practice medicine in the State of Nevada. I have treated the above-named patient from DATE _____ to _____

I most recently saw the patient on ____/____/____, at _____
(Name of Facility)

This adult patient suffers from (Diagnosis):

_____
_____
_____
_____
_____

which is a _____ Permanent Condition _____ Temporary Condition.

I certify that this adult patient is unable to respond (check all that apply; at least one must be provided:

_____To a substantial and immediate risk of physical harm.

_____To an immediate need for medical attention.

_____To a substantial and immediate risk of financial loss.

Describe immediate risk or need:

_____
_____
_____
_____

Attached hereto is (check all that apply; at least one must be provided):

_____ A copy of my report of the above exam which includes my findings, opinion and diagnosis regarding the patient and his/her metal condition and/or capacity.

_____ A copy of the patient's chart notes which support and/or detail my findings, opinion and diagnosis regarding the patient and his/her mental condition and/or capacity.

_____ A letter, signed by me, detailing my findings, opinion and diagnosis regarding the patient and his/her mental condition and/or capacity.

My opinion of the patient's mental capacity and/or ability to function independently without assistance of others is

_____
_____
_____
_____

My opinion as to the patient's risk of harm and need for supervision is as follows:

The patient's risk of harm to self is:
_____Mild _____Moderate _____Severe

The patient's risk of harm to others is:
_____Mild _____Moderate _____Severe

The patient's level of needed supervision is as follows:
_____Locked Facility _____24 Hour Supervision _____No Supervision
_____Independent Living/Some Supervision _____ No Supervision When Taking Meds

My opinion as to the patient's everyday functions is as follows:

CARE OF SELF (ACTIVITIES OF DAILY LIVING (ADL's) AND RELATED ACTIVITIES

Maintain adequate hygiene, including bathing, dressing, toileting, dental
____Independent ____Needs Support ____Needs Assistance ____Total Care
Prepare meals and eat for adequate nutrition
____Independent ____Needs Support ____Needs Assistance ____Total Care
Identify abuse or neglect and protect self from harm
____Independent ____Needs Support ____Needs Assistance ____Total Care

FINANCIAL

Manage and use checks, deposit, withdraw, dispose, invest monetary assets
____Independent ____Needs Support ____Needs Assistance ____Total Care
Enter into a contract, financial commitment, or lease arrangement
____Independent ____Needs Support ____Needs Assistance ____Total Care
Employ persons to advise or assist him/her
____Independent ____Needs Support ____Needs Assistance ____Total Care
Resist exploitation, coercion, undue influence
____Independent ____Needs Support ____Needs Assistance ____Total Care

MEDICAL

Give/Withhold medical consent
____Independent ____Needs Support ____Needs Assistance ____Total Care
Admit self to health facility
____Independent ____Needs Support ____Needs Assistance ____Total Care
Make or change an advance directive
____Independent ____Needs Support ____Needs Assistance ____Total Care
Manage medications
____Independent ____Needs Support ____Needs Assistance ____Total Care
Contact help if ill or in medical emergency
____Independent ____Needs Support ____Needs Assistance ____Total Care

HOME & COMMUNITY LIFE

Choose/Establish abode
____Independent ____Needs Support ____Needs Assistance ____Total Care
Maintain reasonably safe and clean shelter
____Independent ____Needs Support ____Needs Assistance ____Total Care
Drive or use public transportation
____Independent ____Needs Support ____Needs Assistance ____Total Care
Make and communicate choices regarding roommates
____Independent ____Needs Support ____Needs Assistance ____Total Care
Avoid environmental dangers such as stove and poisons, obtain medical help
____Independent ____Needs Support ____Needs Assistance ____Total Care

Legal Documents. Does patient have the capacity necessary to understand and execute testamentary or legal documents? (i.e. will or trust) ☐ Yes ☐ No ☐ Uncertain

Voting. Does patient have the capacity necessary to understand and complete voter registration forms and to vote? ☐ Yes ☐ No ☐ Uncertain

Driving. Is patient capable of driving ☐ Yes ☐ No ☐ Uncertain

The patient should _____ or should not _____ be required to attend a hearing on the petition for guardianship. If the patient should not attend, please explain:

_____
_____
_____
_____

Because I do not believe the patient should attend a guardianship hearing, I informed the patient of the patient's right to an attorney in the guardianship proceedings.

_____Yes _____No

_____ Patient has requested appointment of an attorney.

_____ Patient would not comprehend the need for attorney representation.

_____Discussing the need for attorney representation with client would be detrimental to the patient's mental health.

Response of patient:

_____
_____
_____

My opinion as to the patient's need for a guardian is as follows:
_____The patient does not need a guardian.
_____The patient needs only a guardian of the person.
_____The patient needs only a guardian of the estate.
_____The patient needs a guardian of the person and estate to make medical and financial decisions.

Is there any additional information that the Court should also be aware of which concerns the Proposed Ward and is not included above, but may be of interest to the Court?

DATED this ___ day of _____, 200__.

_____
(Signature of doctor, psychologist or psychiatrist)

_____
(Printed name of doctor, psychologist or psychiatrist)

DATED this ___ day of _____, 200__.

_____
(Signature of case manager or social worker)

_____
(Printed name of case manager or social worker)

Attn: Physician: Please Attach Certificate abiding by the Excerpt from Nev. Rev. Stat. 159.0523 Documentation which shows the proposed ward faces a substantial and immediate risk of physical harm or needs immediate medical attention and lacks capacity to respond to the risk of harm or obtain the necessary medical attention. Such documentation must include, without limitation, a certificate signed by a physician who is licensed to practice medicine in this State or who is employed by the Department of Veterans Affairs, a letter signed by any governmental agency in this State which conducts investigations or a police report.