PHYSICIAN'S CERTIFICATE WITH NEEDS ASSESSMENT

(Please print clearly or type)

I, _____, am a physician licensed to practice in the State of
Physician's Full Name

Nevada.

I examined _____, an adult, on _____.
Patient's Full Name Date of Exam

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 mental 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 (IF APPROPRIATE NOTE DOLLAR LIMITS)

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

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 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.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: _____ _____
Physician's Signature

_____
Print Physician's Name

Address: _____
_____
_____