DECISION-MAKING ASSESSMENT TOOL

(FOR LIMITED GUARDIANSHIP OR GUARDIANSHIP)

Name of Individual being assessed: _____

Date of birth: _____

Current address:

_____
No. Street

_____
City/Town State Zip Phone Number

Permanent address (if different):

_____
No. Street

_____
City/Town State Zip Phone Number

Instructions for Completion

This document will be used by a Probate Court to determine whether to appoint a guardian to assist this individual in some or all areas of decision-making.

This document has two parts. Please first complete the part which is right after these instructions, titled Assessment. Then complete the second section, titled Summary.

To a physician completing this document: The individual's treating physician must complete this document. If there is any information of which the treating physician does not have direct knowledge, he or she is encouraged to make such inquiries of such other persons as are necessary to complete the entire form. Those persons might include other medical personnel such as nurses, or other persons such as family members or social service professionals who are acquainted with the individual. If the physician has received information from others in completing this form, the names of those individuals must be listed on the Summary.

To a non-physician completing this document: Professionals or other persons acquainted with the individual being assessed may also complete this document. If there is information of which a non-physician does not have knowledge, such non-physician may either leave portions of the document blank, or also make inquiries or do such investigation as is necessary to complete the entire document. Again, the names of any individual from whom information is derived should be listed on the Summary.

The document must be signed and dated by the person completing it. It does not need to be notarized.

A. BIOLOGICAL ASSESSMENT

THE FOLLOWING IS BASED UPON A PHYSICAL EXAMINATION CONDUCTED

BY ME ON (DATE): _____

1. DIAGNOSIS and PROGNOSIS:

_____

_____

_____

_____

2. MEDICATIONS (PLEASE LIST):

_____

_____

_____

_____

How do the above medications, if any, affect the individual's decision-making ability?
Please explain:

_____

_____

_____

_____

3. CURRENT NUTRITIONAL STATUS:

_____

_____

_____

_____

B. PSYCHOLOGICAL ASSESSMENT

1. MEMORY (CHECK ONE)

[ ] A. Intact
[ ] B. Mild Impairment
[ ] C. Moderate Impairment
[ ] D. Severe Impairment

2. ATTENTION (CHECK ONE)

[ ] A. Intact
[ ] B. Mild Impairment
[ ] C. Shifting/Wandering
[ ] D. Delirium
[ ] E. Unresponsive

3. JUDGEMENT (CHECK ONE)

[ ] A. Intact
[ ] B. Able to Make Most Decisions
[ ] C. Impaired
[ ] D. Gross Impairment

4. LANGUAGE (CHECK ONE)

[ ] A. Intact
[ ] B. Sensory Deficits: Hearing/Speech/Sight
[ ] C. Impairment in Comprehension/ Speech Mild/Moderate/Severe
[ ] D. Completely Unresponsive

5. EMOTION (CHECK ALL THAT APPLY)

A. ANXIETY/DEPRESSION

[ ] 1. None
[ ] 2. History of Anxiety/Depression
[ ] 3. Moderate Symptoms of Anxiety/Depression
[ ] 4. Severe Symptoms with sleep/appetite/energy disturbance
[ ] 5. Suicidal/Homicidal

B. OTHER

[ ] 1. Suspiciousness/Belligerence/Explosiveness
[ ] 2. Delusions/Hallucinations
[ ] 3. Unresponsive

If you checked any of the above, other than "A" or "1" for any of the above categories, please explain whether the situation is treatable or reversible, and if so, how:

_____

_____

_____

_____

_____

_____

_____

_____

C. SOCIAL ASSESSMENT

1. MOBILITY (CHECK ALL THAT APPLY)

[ ] A. Intact/Exercises
[ ] B. Drives Car or Uses Public Transportation
[ ] C. Independent Ambulation in Home Only
[ ] D. Walker/Cane
[ ] E. Requires Assistance

If you checked "C", "D", or "E", is situation treatable or reversible? If so, how?

_____

_____

_____

2. SELF CARE (CHECK ALL THAT APPLY)

[ ] A. No Assistance Needed
[ ] B. Requires Assistance with:
- [ ] 1. Meals
- [ ] 2. Bathing
- [ ] 3. Dressing
- [ ] 4. Toileting/Feeding

If you checked any choices under "B", is individual aware that assistance is required? _____

Is individual willing to accept assistance? _____

Is individual able to arrange for assistance? _____

3. CARE PLAN MAINTENANCE (CHECK ALL THAT APPLY)

[ ] A. No Active Problem
[ ] B. Initiates Problem Identification
[ ] C. Actively Cooperative
[ ] D. Passively Cooperative
[ ] E. Passively Uncooperative
[ ] F. Actively Uncooperative

4. SOCIAL NETWORK RELATIONSHIPS (CHECK ONE IN "A" AND ONE IN "B")

A. SUPPORT
- [ ] 1. Very Good Supportive Network
- [ ] 2. Some Support from Family & Friends
- [ ] 3. No or Limited Support from Family & Friends
- [ ] 4. Needs Community Support
- [ ] 5. Isolated/Homebound

B. SOCIAL SKILLS
- [ ] 1. Very Good Social Skills
- [ ] 2. Good Social Skills
- [ ] 3. Interacts with Prompting
- [ ] 4. Isolated

D. SUMMARY

I hereby certify that I have reviewed sections A, B, & C attached hereto and based on such assessments that the individual's decision-making ability is as follows:

(1) Please describe as fully as you can the individual's decision-making ability in each of the following areas:

(A) FINANCIAL MATTERS: _____

_____

_____

(B) HEALTH CARE MATTERS: _____

_____

_____

(C) RELATIONSHIPS: _____

_____

_____

(D) RESIDENTIAL MATTERS: _____

_____

_____

(2) Please indicate your opinion regarding whether the individual needs a substitute decision-maker in any of the following areas: (Check one for each category. If you check "limited" for any category, please explain.)

(A) FINANCIAL MATTERS	[ ] YES	[ ] NO	[ ] LIMITED _____
(B) HEALTH CARE MATTERS	[ ] YES	[ ] NO	[ ] LIMITED _____
(C) RELATIONSHIPS	[ ] YES	[ ] NO	[ ] LIMITED _____
(D) RESIDENTIAL MATTERS	[ ] YES	[ ] NO	[ ] LIMITED _____

(E) OTHER: If there are any other areas in which you think the individual lacks decision-making ability or has limited decision-making ability, please explain:

_____

_____

_____

_____

Signature

Name (Print or Type)

Title

Date

Names and titles of others who assisted in Preparation of this Assessment: