PHYSICIAN'S CERTIFICATE WITH NEEDS ASSESSMENT
(Please Print Clearly or Type)

I, _____ (your name), am a physician licensed to practice in the State of Nevada. I examined _____ (patient's name), an adult on _____ (date). The patient suffers from (diagnosis): _____

_____

_____

Which is a ❑ Permanent Condition ❑ Temporary Condition.

I certify that this 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 the immediate risk or need: _____

_____

_____

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

- ❑ A copy of my report of the exam which includes my findings, opinion and diagnosis regarding the patient and the patient's mental condition or capacity.
- ❑ A copy of the patient's chart notes which support and/or detail my findings, opinion and diagnosis regarding the patient and the patient's mental condition and/or capacity.
- ❑ A letter, signed by me, detailing my findings, opinion and diagnosis regarding the patient and the patient's mental condition and/or capacity.

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

❑ Locked Facility ❑ 24 Hour Supervision ❑ No Supervision

❑ Independent Living/Some Supervision

❑ No Supervision When Taking Meds

My option as to the patient's every day functions is:

<u>Care of Self (Activities of Daily Living, a.k.a. ADLS, and Related Activities)</u>

Maintains 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, deposits, withdrawals, dispose of, and 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 or 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 a medical emergency

❑ Independent ❑ Needs Support ❑ Needs Assistance ❑ Total Care

Home and Community Life

Choose and Establish an 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

<u>Capacity and Attendance at Hearings</u>

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

_____

_____

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

❑ 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 the patient: _____

_____

_____

Does the patient have the capacity necessary to understand and execute testamentary document, like a will, trust, and powers of attorney? ❑ Yes ❑ No ❑ Uncertain

Would the patient present a risk or threat to self or others if the patient were to own or possess a firearm? ❑ Yes ❑ No ❑ Uncertain

Does the patient have the mental capacity to vote because he or she cannot communicate, with or without accommodations, a specific desire to participate in the voting process? ❑ Yes ❑ No ❑ Uncertain

Guardianship

My opinion as to the patient's need for a guardian is:

❑ The patient is capable of living independently and does not need a guardian

❑ The patient is capable of living independently or with minimal supervision, but requires oversight to take medications and/or assistance with medical and financial matters.

❑ The patient needs a guardian of the person

❑ The patient needs a guardian of the estate

❑ The patient is not capable of living independently, and does not need a guardian.

❑ The patient is not capable of living independently, and requires oversight to take medications and/or assistance with medical and financial matters.

❑ The patient needs a guardian of the person

❑ The patient needs a guardian of the estate

❑ The patient cannot live independently and needs a guardian of the person and estate to for all medical and financial decisions.

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

Dated: _____ Signature: _____

Print Name: _____

Address: _____

_____

Phone Number: _____