

IN THE CHANCERY COURT FOR SUMNER COUNTY, TENNESSEE

IN THE MATTER OF:

DOCKET NO:

RESPONDENT

REPORT OF PHYSICIAN

In accordance with Tennessee Code Annotated, Section 34-13-105, the following report of the Respondent is made by DR. _____.

1. Are you duly licensed to practice in Tennessee? YES NO
2. Have you made a personal physical and mental examination of the Respondent? YES NO
If YES, when? _____
3. What is the medical history of the Respondent? _____

4. What is the nature of his/her disability or disabilities? _____

5. Please indicate your evaluation of the Respondent in the following areas. Please check one in each category.

	<u>Excellent</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>	<u>Chronic</u>	<u>N/A</u>
Mental Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Educational Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adaptive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impact of current living conditions on his/her disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Do you feel that the Respondent is in need of a Conservator or Guardian to act on his/her behalf as a fiduciary?
 YES NO

7. Indicate the type and scope of Conservatorship or Guardianship that you feel the Respondent needs by checkmark below:
- Fiduciary for his/her physical well being
 - Fiduciary to handle his/her financial affairs
 - Fiduciary to consent to medical treatment
 - Fiduciary to consent to relocation
 - No Fiduciary needed

8. Please indicate your recommendation as to the most appropriate rehabilitation plan. Check all appropriate answers.
- Physical Therapy
 - Bed Rest
 - Continued Medical Treatment
 - No Rehabilitation Plan Feasible

9. Is the Respondent currently taking any medication? YES NO

10. If YES, please state the type of medication and the usual dosage: _____

11. Please indicate how the medication of the Respondent will affect the following. Please check the appropriate response in each category.

	<u>No Affect</u>	<u>Will Affect</u>	<u>Will Impair</u>	<u>Cannot Determine</u>
Mental Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Educational Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adaptive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PENALTY OF PERJURY DECLARATION, PURSUANT TO T.R.C.P. 72 – I DECLARE, UNDER PENALTY OF PERJURY, THAT THE FOREGOING SWORN REPORT OF PHYSICIAN IS TRUE AND CORRECT.

Physician Signature: _____

Print Physician Name: _____

Office Address: _____

Date Signed: _____