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_____date of exam** ☐ NO
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.

	Excellent	Good	Fair	Poor	Chronic	N/A
Mental Condition	☐	☐	☐	☐	☐	☐
Physical Condition	☐	☐	☐	☐	☐	☐
Social Condition	☐	☐	☐	☐	☐	☐
Educational Condition	☐	☐	☐	☐	☐	☐
Adaptive Behavior	☐	☐	☐	☐	☐	☐
Social Skills	☐	☐	☐	☐	☐	☐
Impact of current living conditions on his/her disability	☐	☐	☐	☐	☐	☐

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 mediation? ☐ 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.

	No Affect	Will Affect	Will Impair	Cannot Determine
Mental Condition	☐	☐	☐	☐
Physical Condition	☐	☐	☐	☐
Educational Behavior	☐	☐	☐	☐
Adaptive Behavior	☐	☐	☐	☐
Social Skills	☐	☐	☐	☐

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: _____