

PROBATE COURT OF CUYAHOGA COUNTY, OHIO

ANTHONY J. RUSSO, Presiding Judge

LAURA J. GALLAGHER, Judge

IN THE MATTER OF THE GUARDIANSHIP OF _____

CASE NUMBER: _____

STATEMENT OF EXPERT EVALUATION

[Sup. R. 66 & R.C. 2111.49]

Definition of Incompetent (R.C. 2111.03(D)): "Incompetent" means any person who is so mentally impaired as a result of a physical or mental illness or disability, or mental retardation, or as a result of chronic substance abuse, that the person is incapable of taking proper care of the person's self or property or fails to provide for the person's family or other persons for whom he is charged by law to provide, or any person confined to a correctional institution within this State."

The Statement of Evaluation does not declare the individual competent or incompetent, but is evidence to be considered by the Court. The fee for completing the evaluation WILL NOT be paid by the Court. Each evaluator should secure payment from the Applicant/Guardian..

1. This Statement of Expert Evaluation is to be filed with the attached to:
- A. Guardianship Application. Completed by Licensed Physician or Licensed Clinical Psychologist prior to the filing and attached to the application.
 - B. Guardian's Report: Completed by Licensed Physician or Licensed Clinical Psychologist Licensed Independent social worker Licensed professional Clinical Counselor or Mental Retardation Team
 - C. Application for emergency Guardian of the person: a Licensed Physician shall complete the Supplement for Emergency Guardian, Form 17.1 A with specificity indicating the emergency, and why immediate action is required to prevent significant injury to the person. The supplement shall be signed, dated, and attached as part of this completed Statement.

2. Statement completed by:
Name & Title Profession: _____

Business Address: _____

Business Telephone Number: _____

3. Date(s) of evaluation: _____

Place(s) of evaluation: _____

Amount of time spent of evaluation: _____

Length of time the individual has been your patient: _____

CASE NUMBER: _____

4. Is the individual presently under medication? Yes No If yes, What is the medication, dosage, and purpose? _____

Are there any signs of physical and/or mental impairments caused by the medication themselves?

5. Is the individual mentally impaired? Yes No If yes, indicate the diagnosis below:

mental retardation/Developmental Disabilities:

Profound

Severe

Moderate

Mild

Mental Illness: Type and Severity _____

Substance Abuse: Description _____

Dementia: Description _____

Other: Description _____

Please provide additional comments and test scores if available.

(Continue comments on page 4): _____

6. During the examination did you notice an impairment of the individual's:

- | | | | |
|------------------------------------|------------------------------|-----------------------------|----------------------------------|
| a) Orientation | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| b) Speech | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| c) Motor Behavior | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| d) Thought process | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| e) Affect | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| f) Memory | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| g) Concentration and comprehension | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| h) Judgement | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

7. Please describe any impairments identified in question six. (Continue comments on page 4)

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8. Is the individual physically impaired? Yes No If yes: Description _____
9. Are there any special characteristics of the individual which should be considered in evaluating the individual for guardianship?: Yes No If yes: Explain _____
10. Are there any indications of abuse, neglect or exploitation of the individual?
 Yes No If yes: Explain _____
11. Do you believe the individual is capable of caring for the individual's activities of daily living or making decisions concerning medical treatments, living arrangements and diet?
 Yes No If no: Explain _____
12. Do you believe this individual is capable of managing the individual's finances and property?
 Yes No If no: Explain _____
13. Prognosis:
A. Is the condition stabilized? Yes No
B. Is the condition reversible? Yes No
14. In my opinion a guardianship should be:
 Established/Continued
 Denied/Terminated

I certify that I have evaluated the individual on _____, 20_____.

Date: _____

Signature of evaluator

GUARDIAN'S REPORT ADDENDUM

(Not to be used with initial Application)

It is my opinion, based upon a reasonable degree of medical or psychological certainty, that the mental capacity of this ward will not improve.

Date _____

Signature - Licensed Physician/Clinical Psychologist

Probate Court of Cuyahoga County, Ohio

ANTHONY J. RUSSO, Presiding Judge

LAURA J. GALLAGHER, Judge

IN THE MATTER OF THE GUARDIANSHIP OF _____

CASE NUMBER: _____

SUPPLEMENT FOR EMERGENCY GUARDIAN OF PERSON

[R.C. 2111.49]

This Supplement must be completed when there is a request for Emergency Guardianship. The following questions must be answered with specificity and item 1.C, page 1 of the Statement of Expert Evaluation, Form 17.1 must be checked.

A. Does the individual have a durable health care power of attorney? _____ If yes, why is it not being honored?

B. Exact nature of emergency: _____

C. Length of time emergency has existed, and why? _____

D. Specific action required to prevent significant injury to the person: _____

E. Ability of the alleged Incompetent to receive notice and give consent: _____

F. Medical prognosis in detail if immediate action, within 24 hours, is not taken: _____

G. Additional statements regarding condition, family, support services, etc.: _____

Note: Any above answers may be supplemented by attachments

Date and Time of Evaluation

Licensed Physician

Date of Report