

PROBATE COURT OF \_\_\_\_\_ COUNTY, OHIO

IN THE MATTER OF THE GUARDIANSHIP OF \_\_\_\_\_

CASE NO. \_\_\_\_\_

STATEMENT OF EXPERT EVALUATION

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

Definition of Incompetent (R.C. 2111.01(D)): "Incompetent" means any person who is so mentally impaired as a result of a mental or physical 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 the person 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 this evaluation WILL NOT be paid by the Probate Court. Each evaluator should secure payment from the Applicant/Guardian.

1. This Statement of Expert Evaluation is to be filed with or 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  Licensed Clinical Psychologist  Licensed Independent Social Worker  Licensed Professional Clinical Counselor or  Mental Retardation Team.

The evaluation or examination shall be completed within three months prior to the date of the Report. R.C. 2111.49

C. Application for Emergency Guardian:  of the person: a Licensed Physician shall complete the Supplement for Emergency Guardian, form 17.1A 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 on evaluation: \_\_\_\_\_

Length of time the individual has been your patient:

\_\_\_\_\_

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 medications 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) Judgment                        | <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).

\_\_\_\_\_

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 indication 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 \_\_\_\_\_

