PHYSICIAN'S CERTIFICATE WITH NEEDS ASSESSMENT
(Please answer all questions)

I, ______________________________, am qualified in the following way to complete this form:
Full Name

□ Yes □ No I am a physician licensed to practice in the State of Nevada.
□ Yes □ No I am a physician who is employed by the Department of Veterans Affairs.
□ Yes □ No I am a person who is otherwise qualified to execute the certificate. My qualifications are as follows:

____

____

____

____

SECTION I

I examined ____________________________________, an adult, on_______________________.
Patient's Full Name Date of Exam

This patient's diagnosis and condition is:____

____

____

____

____

In addition to examining the patient, I reviewed the following documents:

____

____

____

____

Revised 8/3/2010.

I certify that this adult patient is unable to respond (check all that apply):

_____ 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 immediate risk or need: ____

____

____

____

____

Does the patient present a danger to himself/herself? □ Yes □ No
Does the patient present a danger to others? □ Yes □ No
Why or why not?

____

____

____

____

Has the patient been subjected to abuse, neglect, or exploitation? □ Yes □ No
If yes, explain:

____

____

____

____

Attached hereto is (check all that apply):

_____ A copy of my report of the above exam which includes my findings, opinion and diagnosis regarding the patient and his/her mental condition and/or capacity.

_____ A copy of the patient's chart notes which support and/or detail my findings, opinion and diagnosis regarding the patient and his/her mental condition and/or capacity.

_____ A letter, signed by me, detailing my findings, opinion and diagnosis regarding the patient and his/her mental condition and/or capacity.

SECTION II

Does the patient need a guardian? □ Yes □ No
Why?

____

____

____

____

Is the patient capable of living independently with or without assistance? □ Yes □ No
Why or why not?

____

____

____

____

SECTION III

The patient's level of needed supervision is as follows:

- □ Locked Facility
- □ 24 hour supervision
- □ Independent living with some supervision
- □ No supervision
- □ No supervision when taking medication

My opinion as to the patient's everyday functions is as follows:

Independent	Needs Support	Needs Substantial Assistance	Needs Total Care	**CARE OF SELF (Activities of Daily Living (ADLs) and related activities)**
				Maintain adequate hygiene, including bathing, dressing, toileting, dental
				Prepare meals and eat for adequate nutrition
				Identify abuse or neglect and protect self from harm

Revised 8/3/2010.

Independent	Needs Support	Needs Substantial Assistance	Needs Total Care	**FINANCIAL**
				Manage and use checks, deposit, withdraw, dispose, invest monetary assets
				Enter into a contract, financial commitment, or lease arrangement
				Employ persons to advise or assist him/her
				Resist exploitation, coercion, undue influence

Independent	Needs Support	Needs Substantial Assistance	Needs Total Care	**MEDICAL**
				Give/Withhold medical consent
				Admit self to health facility
				Make or change an advance directive
				Manage medications
				Contact help if ill or in medical emergency

Independent	Needs Support	Needs Substantial Assistance	Needs Total Care	**HOME AND COMMUNITY LIFE**
				Choose./Establish abode
				Maintain reasonably safe and clean shelter
				Drive or use public transportation
				Make and communicate choices about roommates
				Avoid environmental dangers such as stove, poisons, and obtain emergency help

SECTION IV

Would the patient's attendance at a hearing be detrimental to him/her? □ Yes □ No
If yes, why?

____

____

____

____

Would attendance at the hearing be detrimental to the physical health of the patient? □ Yes □ No
If yes, why?

____

____

____

____

Is the patient able to appear at a hearing? □ Yes □ No
If no, why not?

____

____

____

____

Would the patient comprehend the reason for a hearing? □ Yes □ No

Would the patient contribute to a hearing? □ Yes □ No

If you conclude the patient cannot attend the hearing, please do the following:

- Inform the patient that the petitioner is requesting that the court appoint a guardian for him/her.
- Ask the patient for a response to the guardianship petition.
- Inform the patient of his/her right to counsel and ask whether the patient wishes to be represented by counsel in the guardianship proceeding.
- Ask the preferences of the patient for the appointment of a particular person as the guardian.

I certify that the patient has been advised of his/her right to counsel and asked whether he/she wishes to be represented in the guardianship proceeding. __________ (Please initial).

What was the patient's response to the guardianship petition?

____

____

____

Does the patient want to be represented by counsel in the guardianship proceeding?
□ Yes □ No

Does the patient have any preferences for the appointment of a particular person as guardian?
□ Yes □ No
If yes, what preferences?

____

____

____

____

Are there any conditions that you believe may have limited the responses by the patient?
□ Yes □ No
If yes, what conditions?

____

____

____

____

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

Date: ____________________ Signature: ____

Address: ____

____

Revised 8/3/2010.