

**PROBATE COURT OF MONTGOMERY COUNTY, OHIO
DAVID D. BRANNON, JUDGE**

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, as a result of intellectual disability, 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 Expert 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 being completed for:
 - A. **Initial Guardianship Application:** Must be completed by a ___ Licensed Physician or a ___ Licensed Clinical Psychologist, prior to the filing and attached to the application.
 - B. **Bi-Annual Follow-up Evaluations:** Must be completed by a ___ Licensed Physician ___ Licensed Clinical Psychologist ___ Licensed Independent Social Worker ___ Licensed Professional Clinical Counselor ___ Licensed Certified Nurse Practitioner ___ Licensed Clinical Nurse Specialist, or ___ the Developmental Disability Team
The evaluation or examination shall be completed within three months prior to the date it is filed with the Court. R.C. 2111.49.
 - C. **Application for Emergency Guardian:** Must be completed by a Licensed Physician, who shall also 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 and/or their property. The Supplement shall be signed, dated, and attached as part of this completed Statement.

(please write legibly)

2. Statement completed by:
Printed or Stamped 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:**

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 applicable. (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 indications of abuse, neglect or exploitation of the individual? Yes No
If yes: Explain: _____

11. Do you believe the individual you are evaluating is capable of caring for his/her own activities of daily living or making decisions concerning medical treatments, living arrangements and diet?
 Yes No If no: Explain: _____
12. Do you believe the individual you are evaluating is capable of managing his/her own 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 for Appointment -
Can only be signed by a Licensed Physician/Clinical Psychologist)

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

