



CIRCUIT COURT FOR _____, MARYLAND
City/County

Located at _____ Case No. _____
Court Address

In the Matter of _____

Name of Alleged Disabled Person Docket reference

**PHYSICIAN'S CERTIFICATE
(Md. Rule 10-202(a)(2))**

NOTE TO PHYSICIAN: A petitioner will use this certificate in a legal proceeding to request a guardian for the patient named below. The petitioner must submit the original certificate. Your answers must be specific and detailed and based on your personal examination of the patient. Address each issue contained in the certificate that may interfere with the patient's ability to make responsible decisions about health care, food, clothing, shelter, or property. You may complete the form yourself or have another person complete it under your supervision. Attach additional sheets, if necessary. Your testimony about this information *may* be required at a hearing.

PATIENT'S NAME: _____

PATIENT'S ADDRESS: _____

I, _____
Physician's Name

Address

_____, am a _____ graduate of _____
Telephone Number Year

School of Medicine. I am licensed to practice medicine in the United States in the following state(s):

My license number is: _____

I am board certified in _____. I have known this patient for _____

My history of involvement with the patient is as follows: _____
Length of Time

[Empty box for history of involvement with the patient]

Examination and Diagnosis

I personally examined the above-named patient on _____
Date(s)

(include date of most recent examination, as well as any other relevant visits). The most recent

examination lasted approximately _____
Time

I performed or ordered the following tests and/or

procedures: _____

I communicated with the patient in the following manner:

English

Other language or means (explain):

Upon examination of the patient, I report the following findings:

PHYSICAL AND MENTAL CONDITIONS

Physical conditions

None

The patient has the following physical diagnoses:

.....

Overall physical health: Excellent Good Fair Poor

Explain:

.....

Overall physical health will: Improve Be stable Decline Uncertain

Explain:

.....

Mental conditions

None

The patient has the following mental (DSM) diagnoses:

Axis I.

Mild Moderate Severe

Axis II.

Mild Moderate Severe

Other:

Mild Moderate Severe

Overall mental health will: Improve Be stable Decline Uncertain

If improvement is possible, the individual should be re-evaluated in weeks.

The mental diagnosis/diagnoses affect functioning as follows:

.....

.....

Have any temporary causes of mental impairment been evaluated and treated (e.g., depression, bereavement, or delirium)? Yes No Uncertain

Explain:

Have any reversible causes of mental impairment been evaluated and treated (e.g., coma)?

Yes No Uncertain

Explain:

List all medications:

<u>Name</u>	<u>Purpose</u>	<u>Dosage/Schedule</u>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
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Reversible or temporary somatic factors

Are there factors (e.g., hearing, vision or speech impairment, etc.) that incapacitate the patient that could improve with time, treatment, or assistive devices?

Yes No Uncertain

Explain:

COGNITIVE FUNCTION

Alertness/level of consciousness

Overall impairment: None Mild Moderate Severe Non-responsive

Describe below or in attachment

Memory, cognitive, and executive functioning

Overall impairment: None Mild Moderate Severe Non-responsive

Describe below or in attachment

Fluctuation

Symptoms vary in frequency, severity, or duration: Yes No Uncertain

Describe below or in attachment

EVERYDAY FUNCTIONING

The patient is **capable** of performing the Instrumental Activities of Daily Living (IADLs)

(select all that apply):

- Managing finances effectively
- Managing transportation needs
- Managing communication (e.g., telephone and mail)
- Managing medication
- Other executive functions (describe):

The patient is **capable** of participating in the following civil or legal matters (select all that apply):

- Signing documents
- Retaining legal counsel
- Participating in legal proceedings
- Other (describe):

The patient **does** **does not** require institutional care.

Need for Guardian of Person

In my professional opinion, within a reasonable degree of medical certainty, the patient has a disability which (**select one**) does does not prevent him/her from making or communicating **any** responsible decisions concerning his/her **person**.

OR

In my professional opinion, within a reasonable degree of medical certainty, the patient has a disability which (**select one**) does does not prevent him/her from making or communicating **some** responsible decisions concerning his/her **person**. The patient, for example, is able to make decisions regarding:

but is unable to make decisions regarding:

Need for Guardian of Property

In my professional opinion, within a reasonable degree of medical certainty, the patient has a disability which (**select one**) does does not prevent him/her from making or communicating **any** responsible decisions concerning his/her **property** and has a demonstrated inability to manage his/her **property** and affairs effectively because of physical or mental disability.

OR

In my professional opinion, within a reasonable degree of medical certainty, the patient has a disability which (**select one**) does does not prevent him/her from making or communicating **some** responsible decisions concerning his/her **property**. The patient, for example, is able to make decisions regarding:

.....
.....
.....

but is unable to make decisions regarding:

.....
.....
.....

I solemnly affirm under the penalties of perjury that the contents of this document are true to the best of my knowledge, information, and belief.

.....
Date

.....
Physician's Signature

.....
Printed Name