In the Circuit Court of Davidson County, Tennessee
(Probate Division)

IN THE MATTER OF:

_____ **Docket No.** _____

Respondent

REPORT OF PHYSICIAN

In accordance with *T.C.A. §34-3-105*, the following report is made by Dr. _____

1. **Are you duly licensed to practice in Tennessee?** ☐ **YES** ☐ **NO**

2. **Have you made a personal physical and mental examination of Respondent,** _____ **whose D/O/B is:** _____**?** ☐ **YES**…... **(DATE / required):** _____ ☐ **NO**

3. **What is the medical history of Respondent?**

_____

_____

_____

4. **What is the nature of his/her disability or disabilities?**

_____

_____

_____

5. **Please indicate your evaluation of Respondent in the following areas (*check one in each category*):**

	Excellent	Good	Fair	Poor	Chronic	N/A
Mental Condition	☐	☐	☐	☐	☐	☐
Physical Condition	☐	☐	☐	☐	☐	☐
Social Condition	☐	☐	☐	☐	☐	☐
Educational Condition	☐	☐	☐	☐	☐	☐
Adaptive Behavior	☐	☐	☐	☐	☐	☐
Social Skills	☐	☐	☐	☐	☐	☐
Impact of Current Living Conditions on his/her Disability	☐	☐	☐	☐	☐	☐

6. **Do you feel that Respondent is in need of a Conservator or Guardian to act on his/her behalf as a Fiduciary?**
☐ **YES** ☐ **NO**

7. **Indicate the type and scope of Conservatorship or Guardianship that you feel Respondent needs (*check all that apply*):**

- ☐ **Fiduciary for his/her physical well being**
- ☐ **Fiduciary to handle his/her financial affairs**
- ☐ **Fiduciary to consent to medical treatment**
- ☐ **Fiduciary to consent to relocation**
- ☐ **No Fiduciary needed**

8. **Please indicate your recommendation as to the most appropriate rehabilitation plan (*check all appropriate answers*):**

- ☐ **Physical Therapy**
- ☐ **Bed Rest**
- ☐ **Continued Medical Treatment**
- ☐ **No Rehabilitation Plan Feasible**

9. **Is the Respondent currently taking any medication? YES ☐ NO ☐**

10. **If answer to #9 above is *YES*, please state the type(s) of medication and the usual dosage:**

_____

_____

_____

_____

11. **Please indicate how Respondent's medication will affect the following (*check appropriate response in each category*):**

	No Affect	Will Affect	Will Impair	Cannot Determine
Mental Condition	☐	☐	☐	☐
Physical Condition	☐	☐	☐	☐
Educational Behavior	☐	☐	☐	☐
Adaptive Behavior	☐	☐	☐	☐
Social Skills	☐	☐	☐	☐

PHYSICIAN: _____
(SIGNATURE)

ADDRESS: _____

_____

DATE: _____, 20_____

STATE OF TENNESSEE
COUNTY OF DAVIDSON

Sworn to and subscribed before me, this _____ day of_____, 20_____.

_____
Notary Public

My Commission Expires:_____

Revised 4/20/16

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