

**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*):

	<u>Excellent</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>	<u>Chronic</u>	<u>N/A</u>
Mental Condition	<input type="checkbox"/>					
Physical Condition	<input type="checkbox"/>					
Social Condition	<input type="checkbox"/>					
Educational Condition	<input type="checkbox"/>					
Adaptive Behavior	<input type="checkbox"/>					
Social Skills	<input type="checkbox"/>					
Impact of Current Living Conditions on his/her Disability	<input type="checkbox"/>					

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*):

	<u>No Affect</u>	<u>Will Affect</u>	<u>Will Impair</u>	<u>Cannot Determine</u>
Mental Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Educational Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adaptive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: _____