PROBATE COURT OF MEDINA COUNTY, OHIO

IN THE MATTER OFTHE GUARDIANSHIP OF _____

Case No.

STATEMENT OF EXPERT EVALUATION

[Sup. R. 66 & O.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, or mental retardation, 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 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 to be filed with or attached to:

   ☐ A. Guardianship Application: Completed by ☐ Licensed Physician or ☐ Licensed Clinical Psychologist prior to the filing and attached to the application.

   ☐ B. Guardian's Report: Completed by ☐ Licensed Physician ☐ Licensed Clinical Psychologist ☐ Licensed Independent Social Worker ☐ Licensed Professional Clinical Counselor or ☐ Mental Retardation Team.
   The evaluation or examination shall be completed within three months prior to the date of the Report. R. C. §2111.49

   ☐ C. Application for Emergency Guardian: ☐ of the person: a Licensed Physician shall 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. The Supplement shall be signed, dated, and attached as part of this completed Statement.

2. Statement completed by:
   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:

☐ Mental Retardation/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 available. (Continue comments on page 4):

6. During the examination did you notice an impairment of the individuals?

a) Orientation	☐ Yes	☐ No	☐ Unknown
b) Speech	☐ Yes	☐ No	☐ Unknown
c) Motor Behavior	☐ Yes	☐ No	☐ Unknown
d) Thought Process	☐ Yes	☐ No	☐ Unknown
e) Affect	☐ Yes	☐ No	☐ Unknown
f) Memory	☐ Yes	☐ No	☐ Unknown
g) Concentration and comprehension	☐ Yes	☐ No	☐ Unknown
h) Judgment	☐ Yes	☐ No	☐ 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 is capable of caring for the individual's activities of daily living or making decisions concerning medical treatments, living arrangements and diet? ☐ Yes ☐ No
If no: Explain

12. Do you believe this individual is capable of managing the individual's 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)

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

ADDITIONAL COMMENTS

Date _____

_____
Signature - Licensed Physician/Clinical Psychologist

Print Form