IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON

IN AND FOR THE COUNTY OF KING

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| In the Guardianship of:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,  An Alleged Incapacitated Person. | )  )  )  )  ) | Case No.:  MEDICAL/PSYCHOLOGICAL REPORT  (MDR) |

**This form is required by Washington state law for all Guardianships. Your assistance in completing this form on or before** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **is appreciated.**

**(Please type or print clearly.)**

I have been chosen by the Guardian ad Litem in the above matter to examine and interview \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and I submit the following report:

My name, title, address, telephone number are as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

1. My education and experiences that are pertinent to the type of disorder or incapacity involved in this case: (*a resume/curriculum vitae may be attached*.). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Date of most recent examination of the Alleged Incapacitated Person (most recent exam must be within 30 days of date of this request): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. A summary of the relevant medical functional, neurological, psychological, or psychiatric history of the Alleged Incapacitated Person as known to me:
4. My findings regarding the Alleged Incapacitated Person’s capacity to manage personal or financial matters are: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
5. The following medication(s) are currently prescribed to the Alleged Incapacitated Person for the following condition(s).

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. The effect of these current medications on the Alleged Incapacitated Person’s ability to understand or participate in the Guardianship proceedings is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
2. My opinion as to the specific assistance the Alleged Incapacitated Person needs (*including items such as household chores, managing finances*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
3. I have also met or spoken with the following individuals regarding the Alleged Incapacitated Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF WASHINGTON THAT THE FOREGOING IS TRUE AND CORRECT.

Signed at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Washington, \_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_200\_\_.

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|  |  |  |
| Signature |  | Printed Name |
|  |  |  |
| Address |  | Telephone/Fax Number |
|  |  |  |
| City, State, Zip Code |  | Email Address |