

**IN THE CIRCUIT COURT, SIXTH JUDICIAL CIRCUIT, FLORIDA  
PROBATE DIVISION**

IN RE: The Matter of

File No. 01- -IN-3

EXAMINING COMMITTEE REPORT FOLLOWING PETITION ALLEGING INCAPACITY

NAME          AGE          DATE OF BIRTH

RESIDENCE

CURRENT LOCATION OF ALLEGED

PRIMARY LANGUAGE OF ALLEGED

**PHYSICIANS REPORT**

Date, time of day and place interview conducted \_\_\_\_\_

Parties present during interview \_\_\_\_\_

If anyone other than AIP answers questions, identify party, question and answer: \_\_\_\_\_

Length of time spent with alleged \_\_\_\_\_

Personal history of alleged:

- Length of time in Pinellas County \_\_\_\_\_
- Relatives residing in area \_\_\_\_\_
- Relatives out of area \_\_\_\_\_

**A. THE RESULTS OF THE COMPREHENSIVE EXAM ARE AS FOLLOWS:**

1. Physical examination

a. Diagnosis: \_\_\_\_\_

b. Prognosis: \_\_\_\_\_

c. Current treatment, including medications: \_\_\_\_\_

d. Recommended treatment: \_\_\_\_\_

e. If physical examination is not completed please explain: \_\_\_\_\_

2. Mental health examination

a. Diagnosis: \_\_\_\_\_

b. Prognosis: \_\_\_\_\_

c. Current treatment, including medication: \_\_\_\_\_

d. Recommended treatment:

Are there treatable sources of the diagnosis?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is the condition reversible?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is the condition stabilized?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

e. If mental health examination is not completed please explain \_\_\_\_\_

3. Functional assessment

a. Findings:

Physical appearance of the ward: \_\_\_\_\_

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Living situation of the alleged incapacitated person:

- Alleged lives in  
 home/apt independently       assisted living facility     nursing home  
 home/apt with live in assistance       other \_\_\_\_\_

If alleged is living in own home:

- Condition of residence \_\_\_\_\_  
 Are phone, heat and air conditioning in working order?       YES       NO  
 Is there adequate and appropriate food in the refrigerator?       YES       NO  
 Are the kitchen appliances in working order?       YES       NO  
 Does the alleged receive in home service i.e.: meals on wheels, home health aids?  
 YES       NO

If so what \_\_\_\_\_

- Does the alleged have supportive devices i.e. glasses, hearing aides, walker, wheelchair?  
 YES       NO

If so what \_\_\_\_\_

- Are the basic health and safety needs of the alleged being met in the home?  
 YES     NO explain \_\_\_\_\_

- Is the current placement appropriate?  
 YES     NO explain \_\_\_\_\_

- Is the level of assistance currently being provided sufficient?  
 YES     NO explain \_\_\_\_\_

- Other concerns and recommendations: \_\_\_\_\_  
 ALF/ Nursing home placement is appropriate?  
 YES     NO explain \_\_\_\_\_
- 

The alleged is capable of performing which of the following activities of daily living (ADL's) and independent activities of daily living (IADL's) without assistance?

- Bathing  
 Dressing  
 Toileting  
 Feeding self  
 **Shopping alone for groceries and clothing**  
 Preparing own meals  
 Using the telephone  
 **Maintain the residence** including housework, laundry and cleaning  
 Maintain personal hygiene  
 **Pay bills and maintain checkbook**  
 Handle cash  
 **Travel alone** on public transportation  
 Initiate doctor appointments and follow through with visits
- Medication management  
 Can fill prescriptions as needed  
 Knows names of medications and purpose  
 Can accurately self medicate?
- Responds appropriately to emergency situations i.e. can dial 911  
 Is aware of and responds appropriately to personal and in home safety issues  
 If assistance is necessary to perform the above activities is the appropriate level of assistance being provided?

YES       NO explain \_\_\_\_\_  
Recommendations \_\_\_\_\_

Cognitive assessment

- Tests performed
  - Folstein Mini Mental Health Status Exam
  - Other \_\_\_\_\_
- Memory \_\_\_\_\_
  - Short term \_\_\_\_\_
  - Remote \_\_\_\_\_
- Orientation to time, place person \_\_\_\_\_
- Confusion \_\_\_\_\_
- Insight and judgment \_\_\_\_\_
- Likelihood of being exploited \_\_\_\_\_
- Are there physical impairments, which might contribute to cognitive deficits?
  - YES
    - Impaired hearing
    - Impaired vision
    - Impaired ability to communicate
    - Bedridden
  - NO
- Decision making ability
  - Simple \_\_\_\_\_
  - Complex \_\_\_\_\_
- Communication skills
  - Verbal \_\_\_\_\_
  - Written \_\_\_\_\_
- Comprehension \_\_\_\_\_
- Knowledge of financial affairs
  - Name and location of bank(s) \_\_\_\_\_
  - Nature and amount of assets \_\_\_\_\_
  - Source and amount of income \_\_\_\_\_

b. Recommendations to improve the functional capacity of the alleged

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. Was there consultation with the family physician as required by F.S. 744.331 (3)(a)?

- YES
- NO

If no please explain \_\_\_\_\_

C. Were prior clinical history and treatment records used?

- YES
- NO

If yes, please identify \_\_\_\_\_

D. Were prior psychological/social records or reports used?

- YES
- NO

If yes, please identify \_\_\_\_\_

E. Other parties interviewed and their relationship to the alleged \_\_\_\_\_

\_\_\_\_\_

G. Factual evaluation of the individual's ability to exercise each of the following civil rights:

1. MARRY

a. Should right be removed?  YES  NO

b. Describe the nature and extent of incapacity \_\_\_\_\_

c. The factual basis for determining that this person lacks the capacity to exercise the right listed above is \_\_\_\_\_

2. VOTE

a. Should right be removed?  YES  NO

b. Describe the nature and extent of incapacity \_\_\_\_\_

c. The factual basis for determining that this person lacks the capacity to exercise the right listed above is \_\_\_\_\_

3. HAVE A DRIVER'S LICENSE

a. Should the right be removed?  YES  NO

b. Describe the nature and extent of incapacity \_\_\_\_\_

c. The factual basis for determining that this person lacks the capacity to exercise the right listed above is \_\_\_\_\_

4. PERSONALLY APPLY FOR GOVERNMENT BENEFITS

a. Should the right be removed?  YES  NO

b. Describe the nature and extent of incapacity \_\_\_\_\_

c. The factual basis for determining that this individual lacks the capacity to exercise the right listed above is \_\_\_\_\_

5. TO TRAVEL

a. Should the right be removed?  YES  NO

b. Should the right be limited?  Yes

If yes, how should it be limited?

Travel limited to within Pinellas County

Travel permitted only with supervision of guardian

Other \_\_\_\_\_

c. Describe the nature and extent of incapacity \_\_\_\_\_

d. The factual basis for determining that this individual lacks the capacity to exercise the right listed above is \_\_\_\_\_

6. TO SEEK OR RETAIN EMPLOYMENT

a. Should the right be removed?  YES  NO

b. Describe the nature and extent of incapacity \_\_\_\_\_

c. The factual basis for determining that this individual lacks the capacity to exercise the right listed above is \_\_\_\_\_

7. TO CONTRACT

a. Should the right be removed?  YES  NO

b. Describe the nature and extent of incapacity \_\_\_\_\_

c. The factual basis for determining that this individual lacks the capacity to exercise the right listed above is \_\_\_\_\_

8. TO SUE AND DEFEND A LAWSUIT

a. Should right be removed?  YES  NO

b. Describe the nature and extent of incapacity \_\_\_\_\_

c. The factual basis for determining that this individual lacks the capacity to exercise the right listed above is \_\_\_\_\_

9. TO MANAGE PROPERTY OR TO MAKE ANY GIFT OR DISPOSITION OF PROPERTY

a. Should right be removed?  YES  NO

b. Describe the nature and extent of incapacity \_\_\_\_\_

c. The factual basis for determining that this individual lacks the capacity to exercise the above right is \_\_\_\_\_

10. TO DETERMINE RESIDENCE

a. Should right be removed?  YES  NO

b. Describe the nature and extent of incapacity \_\_\_\_\_

c. The factual basis for determining that this individual lacks the capacity to exercise the above right is \_\_\_\_\_

11. TO CONSENT TO MEDICAL TREATMENT

a. Should right be removed?  YES  NO

b. Describe the nature and extent of incapacity \_\_\_\_\_

c. The factual basis for determining that this individual lacks the capacity to exercise the above right is \_\_\_\_\_

12. TO MAKE DECISIONS ABOUT SOCIAL ENVIRONMENT OR OTHER SOCIAL ASPECTS OF LIFE

a. Should right be removed?  YES  NO

b. Describe the nature and extent of incapacity \_\_\_\_\_

c. The factual basis for determining that this individual lacks the capacity to exercise the above right is \_\_\_\_\_

H. Other comments, observations and recommendations not included above: \_\_\_\_\_

I. Recommendations for increasing capacity \_\_\_\_\_

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Based on the nature and extent of the individuals incapacity it is recommended that the individual be re-evaluated by the Court in six months to determine if any rights can be restored at that time.

It is my belief based on my examination of this individual and my review of the records that this individual is incapacitated.

The scope of the guardianship is  Plenary  Limited

It is my belief based on my examination of this individual and my review of the records that this individual is not incapacitated in any respect as defined in Florida Statutes, Chapter 744.

Please attach as addenda narrative reports by Committee member as appropriate.

Under penalties of perjury I declare that I have examined the above individual and have based my findings on that examination and review of all pertinent information.

Done this \_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

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(Signature)

(Please print name and address)

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NAME      AGE      DATE OF BIRTH  
RESIDENCE  
CURRENT LOCATION OF ALLEGED  
PRIMARY LANGUAGE OF ALLEGED

**Other Members of Committee:**

Psychologist       Gerontologist       Registered nurse       Nurse practitioner  
 Licensed social worker       Other \_\_\_\_\_

Date, time of day and place interview conducted \_\_\_\_\_

Parties present during interview \_\_\_\_\_

If anyone other than AIP answers questions, identify party, question and answer: \_\_\_\_\_

Length of time spent with alleged \_\_\_\_\_

Personal history of alleged:

Length of time in Pinellas County \_\_\_\_\_  
 Relatives residing in area \_\_\_\_\_  
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**A. THE RESULTS OF THE COMPREHENSIVE EXAM ARE AS FOLLOWS:**

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a. Diagnosis: \_\_\_\_\_

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c. Current treatment, including medication: \_\_\_\_\_

**d. Recommended treatment:**

Are there treatable sources of the diagnosis?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is the condition reversible?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is the condition stabilized?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

e. If mental health examination is not completed please explain \_\_\_\_\_

**2. Functional assessment**

**a. Findings:**

Physical appearance of the ward: \_\_\_\_\_

Living situation of the alleged incapacitated person:

Alleged lives in  
 home/apt independently       assisted living facility       nursing home  
 home/apt with live in assistance       other \_\_\_\_\_

If alleged is living in own home:

Condition of residence \_\_\_\_\_

Are **phone, heat and air conditioning** in working order?  YES  NO

Is there **adequate and appropriate food** in the refrigerator?  YES  NO

Are the **kitchen appliances** in working order?  YES  NO

Does the **alleged receive in home service i.e.: meals on wheels, home health aids?**  
 YES  NO

If so what \_\_\_\_\_

Does the **alleged have supportive devices i.e. glasses, hearing aides, walker, wheelchair?**  
 YES  NO

If so what \_\_\_\_\_

Are the **basic health and safety needs of the alleged being met in the home?**  
 YES  NO explain \_\_\_\_\_

\_\_\_\_\_

Is the **current placement appropriate?**  
 YES  NO explain \_\_\_\_\_

\_\_\_\_\_

Is the **level of assistance currently being provided sufficient?**  
 YES  NO explain \_\_\_\_\_

\_\_\_\_\_

Other concerns and recommendations: \_\_\_\_\_

ALF/ Nursing home placement is appropriate?  
 YES  NO explain \_\_\_\_\_

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Medication management

Can fill prescriptions as needed

Knows names of medications and purpose

Can accurately self medicate?

Responds appropriately to emergency situations i.e. can dial 911

Is aware of and responds appropriately to personal and in home safety issues

If assistance is necessary to perform the above activities is the appropriate level of assistance being provided?  
 YES  NO explain \_\_\_\_\_

Recommendations \_\_\_\_\_

\_\_\_\_\_

Cognitive assessment

Tests performed

**Folstein Mini Mental Health Status Exam**

Other \_\_\_\_\_

Memory \_\_\_\_\_

Short term \_\_\_\_\_

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Orientation to time, place person \_\_\_\_\_

Confusion \_\_\_\_\_

Insight and judgment \_\_\_\_\_

Likelihood of being exploited \_\_\_\_\_

Are there physical impairments, which might contribute to cognitive deficits?

YES

Impaired hearing \_\_\_\_\_

Impaired vision \_\_\_\_\_

Impaired ability to communicate \_\_\_\_\_

Bedridden \_\_\_\_\_

NO

Decision making ability \_\_\_\_\_

Simple \_\_\_\_\_

Complex \_\_\_\_\_

Communication skills \_\_\_\_\_

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Name and location of bank(s) \_\_\_\_\_

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b. Recommendations to improve the functional capacity of the alleged

\_\_\_\_\_

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B. Was there consultation with the family physician as required by F.S. 744.331 (3)(a)?

- YES
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If no please explain \_\_\_\_\_

C. Were prior clinical history and treatment records used?

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Done this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
(Signature)  
(Please print name and address)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

