CIRCUIT COURT FOR _____ **, MARYLAND**
City/County

Located at _____ **Case No.** _____
Court Address

In the Matter of

_____ _____
Name of Alleged Disabled Person Docket reference

PHYSICIAN'S CERTIFICATE
(Md. Rule 10-202(a)(2))

NOTE TO PHYSICIAN: A petitioner will use this certificate in a legal proceeding to request a guardian for the patient named below. The petitioner must submit the original certificate. Your answers must be specific and detailed and based on your personal examination of the patient. Address each issue contained in the certificate that may interfere with the patient's ability to make responsible decisions about health care, food, clothing, shelter, or property. You may complete the form yourself or have another person complete it under your supervision. Attach additional sheets, if necessary. Your testimony about this information *may* be required at a hearing.

PATIENT'S NAME: _____

PATIENT'S ADDRESS: _____

I, _____,
Physician's Name

_____,
Address

_____, am a _____ graduate of _____
Telephone Number Year

School of Medicine. I am licensed to practice medicine in the United States in the following state(s):

, My license number is: _____

I am board certified in _____. I have known this patient for _____ .
Length of Time

My history of involvement with the patient is as follows:

Examination and Diagnosis

I personally examined the above-named patient on _____
Date(s)

(include date of most recent examination, as well as any other relevant visits). The most recent examination lasted approximately _____. I performed or ordered the following tests and/or
Time

procedures: _____

_____

_____

I communicated with the patient in the following manner:

☐ English

☐ Other language or means (explain):

Upon examination of the patient, I report the following findings:

PHYSICAL AND MENTAL CONDITIONS

Physical conditions

☐ None

☐ The patient has the following physical diagnoses:

Overall physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Explain:

Overall physical health will: ☐ Improve ☐ Be stable ☐ Decline ☐ Uncertain
Explain:

Mental conditions

☐ None

☐ The patient has the following mental (DSM) diagnoses:

Axis I.

☐ Mild ☐ Moderate ☐ Severe

Axis II.

☐ Mild ☐ Moderate ☐ Severe

Other:

☐ Mild ☐ Moderate ☐ Severe

Overall mental health will: ☐ Improve ☐ Be stable ☐ Decline ☐ Uncertain

If improvement is possible, the individual should be re-evaluated in _____ weeks.

The mental diagnosis/diagnoses affect functioning as follows:

Have any temporary causes of mental impairment been evaluated and treated (e.g., depression, bereavement, or delirium)? ☐Yes ☐No ☐Uncertain

Explain:

Have any reversible causes of mental impairment been evaluated and treated (e.g., coma)?
☐ Yes ☐ No ☐ Uncertain

Explain:

List all medications:

Name	Purpose	Dosage/Schedule

Reversible or temporary somatic factors
Are there factors (e.g., hearing, vision or speech impairment, etc.) that incapacitate the patient that could improve with time, treatment, or assistive devices?
☐ Yes ☐ No ☐ Uncertain

Explain:

COGNITIVE FUNCTION

Alertness/level of consciousness
Overall impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Non-responsive
Describe below or ☐ in attachment

Memory, cognitive, and executive functioning
Overall impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Non-responsive
Describe below or ☐ in attachment

Fluctuation

Symptoms vary in frequency, severity, or duration: ☐ Yes ☐ No ☐ Uncertain

Describe below or ☐ in attachment

EVERYDAY FUNCTIONING

The patient **is capable** of performing the Instrumental Activities of Daily Living (IADLs) (select all that apply):

- ☐ Managing finances effectively
- ☐ Managing transportation needs
- ☐ Managing communication (e.g., telephone and mail)
- ☐ Managing medication
- ☐ Other executive functions (describe):

The patient **is capable** of participating in the following civil or legal matters (select all that apply):

- ☐ Signing documents
- ☐ Retaining legal counsel
- ☐ Participating in legal proceedings
- ☐ Other (describe):

The patient ☐ **does** ☐ **does not** require institutional care.

Need for Guardian of Person

☐ In my professional opinion, within a reasonable degree of medical certainty, the patient has a disability which **(select one)** ☐ does ☐ does not prevent him/her from making or communicating **any** responsible decisions concerning his/her **person**.

OR

☐ In my professional opinion, within a reasonable degree of medical certainty, the patient has a disability which **(select one)** ☐ does ☐ does not prevent him/her from making or communicating **some** responsible decisions concerning his/her **person**. The patient, for example, is able to make decisions regarding:

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but is unable to make decisions regarding:

Need for Guardian of Property

☐ In my professional opinion, within a reasonable degree of medical certainty, the patient has a disability which **(select one)** ☐ does ☐ does not prevent him/her from making or communicating **any** responsible decisions concerning his/her **property** and has a demonstrated inability to manage his/her **property** and affairs effectively because of physical or mental disability.

OR

☐ In my professional opinion, within a reasonable degree of medical certainty, the patient has a disability which **(select one)** ☐ does ☐ does not prevent him/her from making or communicating **some** responsible decisions concerning his/her **property**. The patient, for example, is able to make decisions regarding:

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but is unable to make decisions regarding:

I solemnly affirm under the penalties of perjury that the contents of this document are true to the best of my knowledge, information, and belief.

Date

Physician's Signature

Printed Name

Reset