

STATE OF SOUTH CAROLINA

COUNTY OF: HORRY

IN THE MATTER OF:

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IN THE PROBATE COURT

**EXAMINER'S / DOCTOR'S AFFIDAVIT AND REPORT
REGARDING CAPACITY**

CASE NUMBER

PERSONALLY APPEARED BEFORE ME

Name of Physician/Examiner

who being duly sworn deposes and says:

I am (Please set forth your medical credentials):

Business address and phone:

Date and Place of this examination:

I have had previous opportunities to evaluate the patient?

Yes No

(If yes, indicate dates and circumstances within the last year and/or reference if you have been the patient's personal physician for a period of time and the time frame.)

Is the patient oriented to time and place?

Yes No

What is the physical condition and age of the patient? (Detail any other significant factors that may be relevant to the Court.)

Set forth the results of any tests which bear on the issue of incapacity and date of test:

Please answer the following questions concerning the above person. Please provide details at end of this form or an attached sheet of paper.

1. Has this person ever been rated or found:

disabled

Yes No Unknown

mentally ill or incompetent

Yes No Unknown

chemically dependent

Yes No Unknown

2. Can the above person:

care for self (personal hygiene)

Yes No Unknown

prepare meals and/or clean house

Yes No Unknown

maintain bank accounts or funds

Yes No Unknown

pay bills

Yes No Unknown

live independently

Yes No Unknown

operate a car

Yes No Unknown

take medications unsupervised

Yes No Unknown

3. Would the above person benefit from:

- | | | | |
|--------------------------------------|------------------------------|-----------------------------|----------------------------------|
| further education | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |
| further training | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |
| therapy of some sort | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |
| medical aids or equipment | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |
| an operation or medical procedure(s) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |
| structured living arrangements | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |

4. Has the above person had in the last six months:

- | | | | |
|--------------------------------------|------------------------------|-----------------------------|----------------------------------|
| hospitalization(s) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |
| therapy or treatment | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |
| inpatient or outpatient surgery | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |
| major medical test(s) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |
| psychological or psychiatric testing | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |

5. In your opinion, does this person have the mental or physical capacity to effectively manage his/her property and financial affairs

Yes No

and /or make necessary daily living and health care decisions

Yes No

6. To your knowledge does this person have:

- | | | | |
|------------------------------------|------------------------------|-----------------------------|----------------------------------|
| a power of attorney | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |
| a health care power of attorney or | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |
| a "living will" | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |

7. Does the above person have any of the following coverages?

- | | | | |
|-----------------------|------------------------------|-----------------------------|----------------------------------|
| health insurance | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |
| medicare | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |
| medicaid | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |
| veteran's health care | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |

8. Does this person have a primary caretaker? Yes No Unknown
If yes, please give available information on name, address, and relationship to above person.

Use this space for explanations or additional comments.

BASED UPON MY EVALUATION OF THIS PATIENT:

I DO NOT believe this patient is an "incapacitated person".¹ I do not find any impairment by reason of mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or other cause to the extent that he/she lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his/her person, property, or finances.

I DO BELIEVE THIS PATIENT IS AN "INCAPACITATED PERSON" and in need of a Guardian and/or Conservator as I find him/her to be impaired by reason of (CHECK ALL THAT APPLY AND SET OUT AND DESCRIBE THE LIMITATIONS RESULTING FROM EACH.)

- Mental Illness
- Mental Deficiency
- Physical Illness or Disability
- Advanced Age
- Chronic Use of Drugs
- Chronic Intoxication
- Other

¹"Incapacitated person" means any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or other cause to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person or property. (Section 62-5-101 of the South Carolina Code of Laws)

Is this condition permanent or temporary? yes no

Can Patient perform activities of daily living? yes no

What other information do you believe would assist the Court in making a determination of capacity?

FURTHER AFFIANT SAYETH NOT.

Physician's Signature: _____

Print Name: _____

Examiner: _____

Credentials (M.D., Ph.D., D.O., R.N.)

Address: _____

Telephone: _____

SWORN to before me this _____ day of
_____ 20 _____

Notary Public for
My Commission Expires: _____

FAILURE TO PROVIDE DETAILED RESPONSES TO THE QUESTIONS ON THIS AFFIDAVIT/REPORT MAY OBLIGATE YOU TO APPEAR AT THE PROBATE COURT HEARING.

All information MUST be typed or clearly printed.