

PROBATE COURT OF LUCAS COUNTY, OHIO
JACK R. PUFFENBERGER, JUDGE

IN THE MATTER OF THE GUARDIANSHIP OF _____

CASE NO.: _____

GUARDIAN'S REPORT
(R.C. 2111.49)

NOTE: If allotted space is inadequate to respond, write "See Exhibit" in the space and add appropriate exhibit letter sequence, then attach exhibit containing information requested for that space.

1. This is the **(check one)**: 1st, 2nd, 3rd, 4th, 5th, 6th, or ____, Guardian's Report.

2. Ward's present address: _____
City _____ State _____
Zip _____ Telephone (____) _____

3. Ward's living arrangements at the above address are best described as:

a. His or her own apartment or home (includes assisted living facilities).

b. Private home or apartment of:

(1) the ward's guardian.

(2) a relative of the ward, whose name is:

_____ and relationship is _____

(3) a non-relative whose name is:

c. A foster, group or boarding home.

d. A nursing home.

e. A medical facility or state institution.

f. Other (describe) _____

g. if c, d, e, or f is checked, complete the following:

(1) The name of the home, facility, or institution

(2) The name of an individual at the home, facility or institution who has knowledge and is authorized to give information to the Court about the ward.

Name _____

Telephone Number (____) _____

4. The ward will be at the address given in Item 2:

a. Indefinitely.

b. Temporarily. The new address and telephone number is:

(1) Unknown. I will provide this information when known.

(2) _____

City _____ State _____

Zip _____ Telephone (____) _____



5. Guardian's contact with the ward:
- a. Approximate number of times the guardian had contact with the ward during the period covered by this report: _____.
 - b. The nature of those contacts (phone, personal, or other): _____.
 - c. Date the ward was last seen by the guardian: _____.

6. Have you observed any major change in the ward's physical or mental condition during the period covered by this report? () Yes () No

If "yes" is checked, briefly describe the changes.

7. The care given to the ward is () Adequate () Not Adequate

If "Not Adequate" is checked, explain:

8. The guardianship should be () Continued () Not Continued

If "Not Continued" is checked, explain:

9. During the period covered by this report, the ward () has () has not been seen by a physician.

If the ward has been seen, the last date was _____ and for the Purpose of _____.

Attached is a statement by a licensed physician, a licensed clinical psychologist, a licensed social worker, or a mental retardation team, that has evaluated or examined the ward within three months prior to the date of this report regarding the need for continuing the guardianship.

{R.C. 2111.49(A)(1)(i)} (Form 17.1)

If an attorney has been consulted on this report: Date _____

Attorney's Name

Guardian's Signature

(Type or print Attorney's Name)

(Type or print Guardian's Name)

(Street)

(Street)

(City, State, Zip Code)

(City, State, Zip Code)

(_____) _____
Telephone Number

(_____) _____
Telephone Number

Sup. Ct. Regis. No.

PROBATE COURT OF LUCAS COUNTY, OHIO
JACK R. PUFFENBERGER, JUDGE

IN THE MATTER OF THE GUARDIANSHIP OF _____

CASE NO.: _____

STATEMENT OF EXPERT EVALUATION

[Sup. R. 66 & 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 or 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 individual's:

a) Orientation Yes No Unknown

a) Speech Yes No Unknown

a) Motor Behavior Yes No Unknown

a) Thought Process Yes No Unknown

a) Affect Yes No Unknown

a) Memory Yes No Unknown

a) Concentration and Comprehension Yes No Unknown

a) 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 indication 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

CASE NO.: _____

ADDITIONAL COMMENTS

Date _____

Signature – Licensed Physician/Clinical Psychologist