CONFIDENTIAL – SEALED

(Copy Receipt) (Clerk's Date Stamp)

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| **SUPERIOR COURT OF WASHINGTON COUNTY OF SPOKANE** | |
| In the Guardianship/Conservatorship of:<br><br>_____<br><br>Respondent / Individual | CASE NO. _____<br><br>**CONFIDENTIAL PROFESSIONAL EVALUATION RCW 11.130.290 Guardianship RCW 11.130.390 Conservatorship** |

**Under Washington State law, Washington Courts are required to order a professional evaluation of an individual subject to a Guardianship or Conservatorship. A Physician, Physician Assistant, Psychologist or Advanced Registered Nurse Practitioner are authorized to complete this report. Your assistance in completing this Evaluation <u>within thirty (30) days</u> of examination is appreciated.**

DATE OF EXAMINATION ON WHICH THIS REPORT IS BASED:

_____

I have been selected by the Court Visitor to examine the above-named individual, and I submit the following evaluation:

<u>Did the individual decline or refuse to participate in this evaluation</u>? Yes or No (circle one)

A. My education and experience is as follows:

_____

_____

_____

_____.

B. Description of the nature, type and extent of the individual's cognitive and functional *abilities* to meet essential requirements for physical health, safety or self-care, including management of his or her own property and financial affairs:

_____

_____

_____

_____.

C. Description of the nature, type and extent of the individual's cognitive and functional *limitations* to meet essential requirements for physical health, safety or self-care, including management of his or her own property and financial affairs:

_____

_____

_____

_____.

D. What is the prognosis for improvement regarding the ability of the individual to manage their property or financial affairs?

_____

_____.

E. What is the prognosis for improvement regarding the ability to meet essential requirements for physical health, safety or self-care, and recommendation for the appropriate treatment, support or habilitation plan:

_____

_____

_____

_____.

F. Did any evaluation conducted (or reviewed) describe or detail the individual's physical and mental condition? If so, please describe diagnoses:

_____

_____

_____

_____.

G. Please describe and include information gained from any evaluation related to educational potential, adaptive behavior or social skills:

_____

_____

_____

_____.

H. The following medication(s) are currently prescribed for the following condition(s).

Medication:_____ Condition:_____

Medication:_____ Condition:_____

Medication:_____ Condition:_____

Medication:_____ Condition:_____

I. The effect of these current medications on the Respondent's cognitive and functional abilities is:

_____.

J. Please identify who you have met or talked to regarding the individual named herein:

_____.

I certify (or declare) under penalty of perjury under the laws of the State of Washington that to the best of my knowledge the statements above are true and correct. Furthermore, I will not be advantaged or disadvantaged by a decision to grant a guardianship or conservatorship or otherwise have a conflict of interest.

SIGNED AT _____, WASHINGTON THIS _____ DAY OF _____, 20_____

| | |
|---|---|
| Signature of Physician/Psychologist/ Advanced Registered Nurse Practitioner/Physician Assistant | Printed Name of Physician/Psychologist/ Advanced Registered Nurse Practitioner/Physician Assistant |
| Address | City, State, Zip Code |
| Telephone/Fax Number | Email Address |