CLINICAL TEAM REPORT	Docket No.	Commonwealth of Massachusetts The Trial Court Probate and Family Court

INSTRUCTIONS FOR COMPLETION

This document will be used by the Probate and Family Court in the process of determining whether to appoint a guardian and/or conservator to assume responsibility for an individual with an intellectual disability. A licensed psychologist, registered physician, and licensed social worker, each of whom is experienced in the evaluation of persons with an intellectual disability, must complete this form.

_____ **Division**

To the licensed psychologist, registered physician, and licensed social worker completing this document:

You must complete this document. If there is any information about which you do not have direct knowledge, you are encouraged to make inquiry of such persons as may be necessary to complete the entire form. These might include other healthcare professionals and/or others acquainted with the individual (*e.g.* family members or social service professionals). Identify sources of written or oral information under Section 1.

If you are completing this form on the computer and additional space is required for any narrative section, the section will expand to permit additional information. Do not use medical terminology and/or abbreviations without explaining them in terms that a lay person can understand.

ALL PAGES AND SECTIONS CONTAINED HEREIN MUST BE COMPLETED

To the Honorable Justices of the Probate and Family Court:

The clinicians listed below in section 8 hereby certify under the penalties of perjury that they:

1. are licensed by the Commonwealth of Massachusetts and are experienced in evaluation of persons with an intellectual disability;
2. personally examined _____ (First Name) _____ (Middle Name) _____ (Last Name) _____ (Age)

   who resides at _____ (Address) _____ (Apt, Unit, No. etc.) _____ (City/Town) _____ (State) _____ (Zip)

Dates of Examination(s):

Licensed psychologist on: _____ Date(s) of Examination(s)

Registered physician specializing in _____ Area of specialty on _____ Date(s) of Examination(s)

Licensed social worker on: _____ Date(s) of Examination(s)

The undersigned are prepared to present a statement of qualifications to the Court by written affidavit or personal appearance if directed to do so.

Prior to examination, the individual was informed that communications would not be confidential.

☐ Yes ☐ No

Explain:

_____

_____

_____

1. CERTIFICATION OF METHODS OF EVALUATION

This form was completed based on an in-person clinical evaluation of the individual.

In addition to a clinical examination, other sources of information for this examination:

☐ Review of intellectual, adaptive and other relevant evaluations;

☐ Discussion with professionals involved in the individual's care;

☐ Discussion with family or friends;

☐ Other.

Names and titles/relationships of those individuals who assisted in preparation of this report:

Name	Title/Relationship to individual

List any intellectual, adaptive or other evaluations reviewed and dates of tests.

Test	Date

State numerical result for IQ test. _____

2. CLINICALLY DIAGNOSED CONDITION(S) THAT MAY RESULT IN INCAPACITY

A. Intellectual Disability

Diagnosis of Intellectual Disability

Does the individual have an Intellectual Disability which is defined in G.L. c. 190B, §5-101(12) as a substantial limitation in present functioning beginning before age 18, manifested by significantly sub average intellectual functioning existing concurrently with related limitations in two or more of the following applicable skills area: communication, self-care, home living, social skills, community use, self-direction, health and safety, functioning academics, leisure and work.

☐ Yes ☐ No

List diagnosis and describe level of Intellectual Disability and impact on capacity to make informed decisions.

_____

_____

_____

B. Other Relevant Diagnoses: (List other relevant physical or mental diagnoses that affect decision making ability.)

_____

_____

_____

C. List all Medications that may influence ability to make informed decisions:

Name of medication/dosage/schedule	Describe any positive or negative influence of each medication on the individual's ability to make informed decisions

D. Factors believed to impede current capacity for decision-making.

Are there any factors that could make the individual appear confused but which could improve with time or treatment, such as delirium, acute medical illness, the interaction of multiple medications, hearing loss, vision loss, bereavement, etc.? If so, describe these factors and explain how functioning might improve:

_____

_____

_____

3. INTRUSIVE TREATMENTS PRESCRIBED/PROPOSED

A. Antipsychotic Medications

☐ Check if the individual is prescribed any antipsychotic medications that may require a Rogers treatment plan.

In your opinion is the individual capable of giving informed consent to treatment with antipsychotic medication?

☐ Yes ☐ No

Explain:

_____

_____

_____

B. Other Intrusive Interventions

☐ Check if other intrusive interventions and/or any extraordinary medical treatments are being proposed at this time, such as electroconvulsive therapy, Level III behavioral treatment plan, sterilization, amputation(s), removal of organ(s) and organ transplant(s).

If checked, describe the procedure or intervention being proposed:

_____

_____

_____

In your opinion is the individual capable of giving informed consent to the proposed intervention?

☐ Yes ☐ No

Explain:

_____

_____

_____

4. SOCIAL NETWORKS TO ASSIST IN DECISION MAKING

Does the individual have a social network that he or she utilizes to assist in decision making?

☐ Yes ☐ No

Explain:

_____

_____

_____

5. RISK OF HARM TO SELF OR OTHERS

A. Nature of Risks. Describe any significant risks of physical or emotional harm to or exploitation of the individual:

_____

_____

_____

B. How severe is risk of harm?

☐ Mild ☐ Substantial ☐ Life Threatening

C. How likely is risk of harm or exploitation?

☐ Almost Certain ☐ Probable ☐ Possible ☐ Unlikely

6. RECOMMENDATION ON GUARDIANSHIP/CONSERVATORSHIP

If seeking guardianship of the person, complete section 6.1. If seeking only a conservatorship, do not complete this section. Limited Guardianship is preferred by the court; describe how the guardianship may be limited. Describe how the assessment was performed and give specific examples.

6.1 GUARDIANSHIP: INABILITY TO MEET ESSENTIAL REQUIREMENTS FOR HEALTH, SAFETY, AND SELF CARE

A. Areas in which the individual is able to make informed decisions with respect to his or her adaptive skill areas including physical health, safety, and self-care:

Describe the individual's retained abilities and adaptive behavior for physical health, safety, self-care for which the guardianship may be limited (*e.g.*, ability to manage ADL's and IADL's such as health, hygiene, home, communication, driving, leisure, social; functioning in the community; ability to express treatment choices and make medical decisions; ability to complete any or some legal transactions).

B. Areas in which the individual is unable to make informed decisions with respect to his or her adaptive skill areas including physical health, safety, or self-care:

Describe the impairments in physical health, safety, and self-care for which the individual requires a Guardian.

C. If individual is unable to make any decisions for him or herself or is unable to make informed decisions with respect to physical health, safety, and self care (*i.e.* requires a full guardianship), describe why:

6.2 CONSERVATORSHIP: INABILITY TO MANAGE PROPERTY OR BUSINESS AFFAIRS EFFECTIVELY

If seeking a full or limited conservatorship of the person, complete section 6.2. Limited Conservatorship is preferred by the court.

A. Areas in which the individual is able to manage property or business affairs effectively:

What abilities can the individual retain in management of his or her property and estate (e.g., ability to manage allowance, bills, donations, investments, real estate, protect assets, resist fraud)?

B. Areas in which the individual is unable to manage property or business affairs effectively:

What are the impairments in the management of property and business affairs for which the individual requires a conservator? Describe how the person has property that will be wasted or dissipated unless management is provided or describe how protection is necessary to provide money for the support, care and welfare of the person or those entitled to the person's support.

C. If the individual is unable to make any decisions about, and is unable to manage, any property or business affairs effectively (*i.e.* requires full conservatorship), describe why:

7. ATTENDANCE AT HEARING

The individual is able to attend the court hearing.

☐ Yes ☐ No

Is it likely that it would be clinically or emotionally harmful for the individual to attend the court hearing?

☐ Yes ☐ No

Explain:

_____

_____

_____

Describe the accommodations, if any, that are required to facilitate the individual's participation in the court hearing:

_____

_____

_____

8. SIGNATURES OF CLINICIANS WHO COMPLETED THIS FORM

This document must be signed and dated by the 3 persons completing it. It does not need to be notarized. *

I hereby certify that the evaluation of this individual is within the scope of my professional competence based upon my education, training and experience. I further certify that this report is complete and accurate to the best of my information and belief.

_____ Date: _____
(SIGNATURE OF LICENSED PSYCHOLOGIST)

_____ _____
(Print name) (License type, number and date)

_____ _____ _____ _____ _____
(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Office Phone #: _____

_____ Date: _____
(SIGNATURE OF REGISTERED PHYSICIAN)

_____ _____
(Print name) (License type, number and date)

_____ _____ _____ _____ _____
(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Office Phone #: _____

_____ Date: _____
(SIGNATURE OF LICENSED SOCIAL WORKER)

_____ _____
(Print name) (License type, number and date)

_____ _____ _____ _____ _____
(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Office Phone #: _____

*** All Signatures must be originals but all signatures need not be on the same page.**