IN THE COURT OF COMMON PLEAS OF NORTHAMPTON COUNTY, PENNSYLVANIA
ORPHANS' COURT DIVISION

IN RE: _____) No.
AN ALLEGED)
INCAPACITATED PERSON)

WRITTEN DEPOSITION OF PHYSICIAN OR LICENSED PSYCHOLOGIST PURSUANT TO 20 Pa.C.S.§5518

Physician or Licensed Psychologist (Name): _____

Office address: _____

Current position: _____

PROFESSIONAL BACKGROUND (In lieu of providing responses to questions 1-6, you may attach your curriculum vitae. Please provide any requested information not addressed in the curriculum vitae.)

1. Provide the following information concerning your education:

	Name of Institution	Degree received	Date of Graduation
Undergraduate			
Graduate			
Post-Graduate			

2. List all of your active professional licenses, the state/name of the issuing agency, and any board certifications, along with the dates each was issued/awarded.

3. Do you have experience in evaluating individuals to determine their mental capacity?

   Yes ___ No ___

4. If your answer to the above question is "Yes", please indicate the basis of your experience and describe your specialized qualifications and training with respect to evaluating persons to determine their mental capacity.

5. Have you ever testified in court or in an administrative proceeding, or have you provided testimony by deposition or by written interrogatories regarding an individual's mental capacity, prior to today?

   Yes ___ No ___

6. If your answer to the above question is "Yes", please provide an estimate of the number of times you provided testimony by deposition or by written interrogatories regarding an individual's mental capacity, prior to today: _____

INFORMATION CONCERNING THE ALLEGED INCAPACITATED PERSON

7. In your professional capacity, have you had the opportunity to meet with, examine, evaluate or assess the alleged incapacitated person?

   Yes ___ No ___

   If your answer to the above question is "Yes", provide the dates within the past two (2) years that you have met with, examined, evaluated or assessed the alleged incapacitated person:

8. Identify any tests that were administered to evaluate/assess the alleged incapacitated person's mental capacity (e.g. mini mental status exam – MMSE), along with the date of each tests and the results/conclusions drawn from each test:

Date	Test	Results/Conclusions

9. Identify all medical and psychiatric diagnoses **that you believe impact the alleged incapacitated person's mental capacity**, along with the symptoms/manifestations of each diagnosis, and the prognosis for each:

Diagnosis	Symptoms/Manifestations	Prognosis

10. List all other current medical diagnoses/conditions of the alleged incapacitated person of which you are aware:

11. List all medications presently prescribed for the alleged incapacitated person, and the diagnosis for which each medication was prescribed:

Medication	Diagnosis

12. Indicate the alleged incapacitated person's abilities with respect to the following activities of daily living by placing an "X" in the appropriate space below:

	No Impairment	Needs Some Help	Totally Impaired	Insufficient Information
Eating				
Bathing				
Dressing				
Toileting				
Transferring				
Preparing meals				
Basic housework				
Personal hygiene				
Managing medication				
Complying with medical treatment				

13. Indicate the alleged incapacitated person's abilities with respect to the following activities by placing an "X" in the appropriate space below. **Additional information will be requested for all items/activities marked "needs some help".**

	No Impairment	Needs Some Help	Totally Impaired	Insufficient Information
Understanding medical conditions and any physical limitations				
Making appropriate living arrangements				
Managing finances/paying bills				
Applying for financial or medical benefits				
Avoiding financial exploitation				
Communicating decisions				
Receiving and evaluating information				
Short term memory				
Long term memory				
Responding to emergency situations				
Providing for his/her physical safety				

14. For all items/activities in the above chart (Interrogatory 13) in which you indicate that the alleged incapacitated person "needs some help", provide details as to the type and extent of assistance needed.

15. List any services that, to your knowledge, are being provided to meet essential requirements for the health and safety of the alleged incapacitated person, or to assist the alleged incapacitated person with management of his/her finances.

16. What, if any, recommendations do you have concerning services necessary to meet essential requirements for the health and safety of the alleged incapacitated person?

17. What, if any, recommendations do you have concerning services necessary to assist the alleged incapacitated person with management of his/her finances?

18. Do you believe that the alleged incapacitated person is capable of making reasonable decisions regarding his/her personal care, medical care, and safety?

    Yes ___ No ___

19. Do you believe that the alleged incapacitated person is capable of making reasonable decisions regarding his/her finances?

    Yes ___ No ___

20. In your professional opinion, is the person who is the subject of this hearing **incapacitated**?

    Yes- totally impaired _____ Yes- partially impaired ___ No ____

21. Do you expect the alleged incapacitated person's mental condition to significantly change or improve? Yes ___ No ___

    Please provide a basis for your answer:

22. Would any less restrictive alternatives to the appointment of a plenary guardian be sufficient to protect the alleged incapacitated person from physical and financial harm?

Yes ___ No ___

If your answer to the above question is "No", explain why less restrictive alternatives would be insufficient to protect the alleged incapacitated person from physical and financial harm?

23. Do you believe that it would be harmful to the alleged incapacitated person's physical or mental condition if he/she was to be present in court for the hearing in this matter?

Yes ___ No ___

24. Are you able to provide any additional information that would assist the Court in determining the alleged incapacitated person's need for a guardian and/or person(s) who would/would not be appropriate guardians?

25. Are your answers to all of the above questions provided within a reasonable degree of medical certainty?

Yes ___ No ___

VERIFICATION

I verify that the foregoing information is true and correct to the best of my knowledge, information and belief. I am aware that this verification is subject to the penalties of 18 Pa.C.S.§4904 relative to unsworn falsification to authorities.

Date

Signature

Name (type or print)

Address

City, State, Zip Code

Phone