PROBATE COURT CITY AND COUNTY OF DENVER, COLORADO City and County Building, Room 230 1437 Bannock Street Denver, CO 80202	
IN THE MATTER OF THE ESTATE OF: _____	**▲Court Use Only▲**
Attorney or Party Without Attorney (Name and Address): Phone Number: E-mail: Fax Number: Atty. Reg. #	Case Number: _____

Clinical Evaluation Report

1. PHYSICAL AND MENTAL CONDITIONS

A. List Physical Diagnoses:

Overall Physical Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

B. List Mental (DSM) Diagnoses:

Overall Mental Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Overall Mental Health will: ☐ Improve ☐ Be stable ☐ Decline ☐ Uncertain

If improvement is possible, the individual should be re-evaluated in _____ weeks.

Focusing on the mental diagnose(s) most impacting functioning, describe relevant history:

C. List all Medications:

Name Dosage/Schedule

These medications may impair mental functioning: ☐ Yes ☐ No ☐ Uncertain

D. Reversible Causes. Have temporary or reversible causes of mental impairment been evaluated and treated? ☐ Yes ☐ No ☐ Uncertain

Explain:

E. Mitigating Factors. Are there mitigating factors (e.g., hearing, vision or speech impairment, bereavement, etc.) that cause the person to appear incapacitated and could improve with time, treatment, or assistive devices?

☐ Yes ☐ No ☐ Uncertain

Explain:

2. COGNITIVE AND EMOTIONAL FUNCTIONING Describe below or ☐ in Attachment the individual's strengths and weaknesses.

A. Alertness/Level of Consciousness

Overall Impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Non Responsive

Describe:

B. Memory and Cognitive Functioning

Overall Impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Describe below or ☐ in Attachment

C. Emotional and Psychiatric Functioning

Overall Impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Describe below or ☐ in Attachment

D. Fluctuation. Symptoms vary in frequency, severity, or duration: ☐ Yes ☐ No ☐ Uncertain

3. EVERYDAY FUNCTIONING. Describe below or ☐ in Attachment the individual's strengths and weaknesses.

A. Activities of Daily Living (ADL'S)

Ability to Care for Self (bathing, grooming, dressing, walking, toileting, etc.)

Level of Function: ☐ Independent ☐ Needs Support ☐ Needs Assistance ☐ Total Care

Describe:

B. Instrumental Activities of Daily Living (IADL'S)

Financial Decision-Making (bills, donations, investments, real estate, wills, protect assets, resist fraud, etc.)

Level of Function: ☐ Independent ☐ Needs Support ☐ Needs Assistance ☐ Total Care

Describe:

Medical Decision-Making (express a choice and understand, appreciate, reason about health info, etc.)

Level of Function: ☐ Independent ☐ Needs Support ☐ Needs Assistance ☐ Total Care

Describe:

Care of Home and Functioning in Community (manage home, health, telephone, mail, drive, leisure, etc.)

Level of Function: ☐ Independent ☐ Needs Support ☐ Needs Assistance ☐ Total Care

Describe:

Other Relevant Civil, Legal, or Safety Matters (sign documents, vote, retain legal counsel, etc.)

Level of Function: ☐ Independent ☐ Needs Support ☐ Needs Assistance ☐ Total Care

Describe:

4. VALUES AND PREFERENCES. Describe below or ☐ in Attachment relevant values, preferences, and patterns. Note whether the person accepts/opposes guardianship, goals for where/how life is lived, religious or cultural considerations.

5. RISK OF HARM AND LEVEL OF SUPERVISION NEEDED

A. Nature of Risks. Describe the significant risks facing this person, and note whether these risks are due to this person's condition and/or due to another person harming or exploiting him or her.

B. Social Factors. Describe the social factors (persons, supports, environment) that decrease the risk or that increase the risk.

C. How **severe** is risk of harm to self or others: ☐ Mild ☐ Moderate ☐ Severe

D. How **likely** is it ☐ Almost Certain ☐ Probable ☐ Possible ☐ Unlikely

E. Level of Supervision Needed. In your clinical opinion:
☐ Locked facility ☐ 24-hr supervision ☐ Some supervision ☐ No supervision

Needs could be met by: ☐ Limited Guardianship ☐ Less Restrictive Alternative
If checked, Explain:

6. TREATMENTS AND HOUSING. The individual would benefit from:

Education, training, or rehabilitation	☐ Yes	☐ No	☐ Uncertain
Mental health treatment	☐ Yes	☐ No	☐ Uncertain
Occupational, physical, or other therapy	☐ Yes	☐ No	☐ Uncertain
Home and/or social services	☐ Yes	☐ No	☐ Uncertain
Assistive devices or accommodations	☐ Yes	☐ No	☐ Uncertain
Medical treatment, operation or procedure	☐ Yes	☐ No	☐ Uncertain
Other: _____	☐ Yes	☐ No	☐ Uncertain

Describe any specific recommendations:

7. ATTENDANCE AT HEARING

The individual can attend the hearing ☐ Yes ☐ No ☐ Uncertain

If no, what are the supporting facts:

If yes, how much will the person understand and what accommodations are necessary to facilitate participation:

8. CERTIFICATIONS

I am a ☐ Physician ☐ Psychologist ☐ Other _____ licensed to practice in the state of _____

Office Address:

Office Phone:

This form was completed based on:
☐ an examination for the purpose of capacity assessment
☐ my general clinical knowledge of this patient

Prior to the examination, I informed the patient that communications would **not** be privileged:
☐ Yes
☐ No

Date of this examination or the date you last saw the patient:

Time spent in examination:

Other sources of information for this examination:
☐ Review of medical record
☐ Discussion with health care professionals involved in the individual's care
☐ Discussion with family or friends
☐ Other

List any tests which bear upon the issue of incapacity and date of tests:

I hereby certify that this report is complete and accurate to the best of my information and belief. I further testify that I am qualified to testify regarding the specific functional capacities addressed in this report, and I am prepared to present a statement of my qualifications to the Court by written affidavit or personal appearance if directed to do so.

SIGNATURE of CLINICIAN DATE

Print name License type, number, and date