NOTE TO MEDICAL STAFF:

- **FAX a copy of the certificate to 214-653-6923**
- **Retain the ORIGINAL certificate in the patient's medical record**
- **ALL sections must be completed before the Court can consider restoration or modification of the Incapacitated Person's rights.**
- **If the examination was conducted by an Advanced Practicing Registered Nurse, the supervising physician shall co-sign below**

Incapacitated Person's Name: _____

Cause No. **PR-____-_____-_____**

CERTIFICATE OF MEDICAL EXAMINATION

_____ has requested a review of his/her guardianship

- ☐ **ALL RIGHTS to be restored**
- ☐ **The following rights be restored or modified:**
- ☐ **Terminate or dissolve the guardianship based on Sufficient Supports and Services**
- ☐ **NO CAPACITY: all rights should remain restricted**

Dallas County Probate Court Investigator's Office
George Allen Courthouse
600 Commerce Street, 9th Floor
Dallas, TX 75202
Business: **214-653-6446 -** Fax: **214-653-6923**

If you or your staff has questions or comments for the court, please call: 214-653-6446

CAUSE NO. PR-_____-_____-_____

IN THE GUARDIANSHIP OF	§	IN PROBATE COURT
	§	
_____	§	NO. _____ OF
	§	
AN INCAPACITATED PERSON	§	DALLAS COUNTY, TEXAS

Certificate of Medical Examination
RESTORATION OF CAPACITY

FAX or MAIL A COPY OF THIS TO:

Keep ORIGINAL for your records.

Dallas County Probate Court
Investigators Office - Court Visitor
600 Commerce Street
9th Floor
Dallas, TX 75202
Fax #214-653-6923

_____ was found to be incapacitated on _____ according to

Texas Estates Code §1002.017

> *An "**Incapacitated Person**" is an adult who, because of a physical or mental condition, is substantially unable to: (a) provide food, clothing, or shelter for himself or herself; (b) care for the person's own physical health; or (c) manage the person's own financial affairs.*

and he/she has **retained** the following civil rights:

☐	**NONE**
☐	Vote
☐	Drive
☐	Decide residence
☐	Marriage
☐	Apply and direct governmental benefits
☐	Other:
☐	Other:

PR-_____-_____-_____

IN THE GUARDIANSHIP OF	§	**IN THE**
	§	
_____,	§	**PROBATE COURT NO. ___ OF**
	§	
AN INCAPACITATED PERSON	§	**DALLAS COUNTY, TEXAS**

RESTORATION CERTIFICATE OF MEDICAL EXAMINATION

Date: _____

Select one: ☐ **I am a physician** currently licensed to practice in the State of Texas; or

☐ **I am an advanced practice registered nurse** acting under a physician's delegation authority and supervision in accordance with Chapter 157, Occupations Code

Examiner's Name: _____

Examiner's Address: _____

Examiner's Telephone: _____

As defined by Estates Code § 1002.17 – "Incapacitated person means (1) a minor; (2) an adult who because of a physical or mental condition, is substantially unable to provide food, clothing, or shelter for himself or herself; care for the persons own physical health; or manage the person's own financial affairs; or (3) a person who must have a guardian appointed for the person to receive funds due the person from a government source."

Dear Judge _____:

I am a Physician or Advanced Practice Registered Nurse currently licensed in the State of Texas. I have been the doctor for the Incapacitated Person for the past _____. The Incapacitated Person was examined by me on _____(date). For the items listed below, based upon my examination and observations, it is my opinion the Incapacitated Person now has the **capacity, or sufficient capacity with supports and services, to do or perform the tasks necessary to:**

A. PERSONAL LIVING DECISIONS

1. Provide food, clothing, and shelter for himself or herself?

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

2. Determine his or her own residence?

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

3. Safely operate a motor vehicle?

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

4. Vote in a public election and serve on a jury?

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

5. Make decisions regarding his or her own marriage?

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

B. BUSINESS AND MANAGERIAL MATTERS; FINANCIAL AFFAIRS

1. Manage his or her own financial affairs?

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

2. Execute a Durable Power of Attorney?

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

3. Contract and incur obligations?

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

4. Manage a bank account?

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

If YES,

a. Should the bank account deposit or balance be limited? ☐ YES ☐ NO--

b. If YES, how much can this person safely manage by themselves? $_____

5. Apply for and receive governmental benefits & services?

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

6. Accept employment?

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

7. Hire employees?

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

8. Sue and defend on lawsuits?

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

9. Make gifts of real or personal property?

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

10. Execute a Health Care Power of Attorney?

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

C. <u>MEDICAL DECISION MAKING</u>

1. Care for his or her own physical health?

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

2. Administer his or her own medications on a daily basis?

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

D. <u>FIREARMS:</u>

1. Purchase a firearm

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

2. Possess a firearm

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

3. Discharge a firearm- Independently

☐ YES ☐ NO ☐ YES, with supports and services (explain) (gun range only)

_____

4. Own or possess firearm ammunition

☐ YES ☐ NO ☐ YES, with supports and services (explain)

_____

E. DAILY LIFE ACTIVITIES

Administer daily life activities (e.g., bathing, grooming, dressing, walking, and toileting):

☐ YES, independently ☐ YES, with assistance ☐ NO, requires total care

Other: (please explain)_____

If you have answered "NO" or "YES, with supports and services" to any of the preceding questions, then answer the following questions:

1. What is the general nature and degree of any incapacity?

2. What is the Incapacitated Person's current medical history as it is related to the incapacity?

3. What is the prognosis, including the estimated severity, of any incapacity?

4. State how, or in what matter, the Incapacitated Person's ability to make or communicate responsible decisions concerning himself or herself is affected by his/her physical or mental health.

5. What medication is the Incapacitated Person on and how is his/her demeanor or ability to participate fully in court proceedings affected?

6. If the underlying diagnosis of the incapacity is that of "senility", please describe the precise physical and mental condition underlying the diagnosis of senility.

THEREFORE, it is my opinion that the Incapacitated Person has:

- ☐ FULL capacity: all rights should be restored.
- ☐ SUFFICIENT CAPACITY with supports and services: all rights should be restored
- ☐ PARTIAL capacity: the above noted rights should be reviewed for restoration.
- ☐ NO capacity and all rights should remain restricted.

Sincerely yours,

Signature:_____
Physician/Psychologist/Advanced Practice Nurse

Printed Name:_____

License #:_____

(If the examination was conducted by an Advanced Practicing Registered Nurse, the supervising physician shall sign below:

_____
Supervising Physician:

License #:_____