

STATE OF SOUTH CAROLINA)
)
COUNTY OF _____)
)
IN THE MATTER OF:)
)
_____,)
)
an alleged incapacitated individual.)
)
)
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)
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IN THE PROBATE COURT
CASE NUMBER _____-GC-_____-_____

**EXAMINER REPORT AND AFFIDAVIT
REGARDING CAPACITY**

Please answer the following questions concerning the alleged incapacitated individual (hereinafter, "patient") and provide explanations or additional comments and details at the end of this form or on an attached sheet of paper.

1. Patient's name: _____
2. Have you treated the patient previously? Yes__ No__

If yes, how long? _____

3. a) Date(s) and place(s) of all examination(s) within previous ninety (90) days:

b) Date(s) and place(s) of all examination(s) relied upon in making this report:

4. Please provide a diagnosis and assessment of the patient's mental and physical condition, including whether he/she is taking any medications that may affect his/her actions:

Are additional tests or assessments, such as lab tests, neuroimaging/MRI, neuropsychological testing, or other tests needed in order to give a more definitive diagnosis? If so, what further tests or examinations are needed?

5. Please specify which diagnoses and/or condition(s) are progressive, permanent, or temporary.
Progressive: _____
Permanent: _____
Temporary: _____

6. Please describe the nature and extent of any incapacity, including specific impairments:

7. Please describe the nature and extent of the patient's abilities, including those that would allow him/her to accomplish certain tasks with reasonably available "supports and assistance"¹:

8. Does the patient have the capacity to retain the following rights (If you cannot attest to yes or no, please explain what additional test/s can be done to achieve that information):

- a) Marry or divorce? Yes__ No__ Unknown__
- b) Reside in a place of his/her choosing, and consent or withhold consent to any residential or custodial placement? Yes__ No__ Unknown__
- c) Travel without the consent of a guardian? Yes__ No__ Unknown__
- d) Give, withhold, or withdraw consent and make other informed decisions relative to medical, mental, and physical examinations, care, treatment, and therapies? Yes__ No__ Unknown__
- e) Make end-of-life decisions including, but not limited to, a "do not resuscitate" order or the application of any medical procedures intended solely to sustain life, and consent or withhold consent to artificial nutrition and hydration? Yes__ No__ Unknown__
- f) Consent or refuse consent to hospitalization and discharge or transfer to a residential setting, group home, or other facility for additional care and treatment? Yes__ No__ Unknown__
- g) Authorize disclosures of confidential information? Yes__ No__ Unknown__
- h) Operate a vehicle*? Yes__ No__ Unknown__
- i) Vote? Yes__ No__ Unknown__
- j) Be employed without the consent of a guardian? Yes__ No__ Unknown__
- k) Consent to or refuse educational services? Yes__ No__ Unknown__
- l) Participate in social, religious or political activities? Yes__ No__ Unknown__
- m) Buy, sell, or transfer real or personal property or transact business of any type? Yes__ No__ Unknown__
- n) Make, modify, or terminate contracts? Yes__ No__ Unknown__
- o) Bring or defend any action at law or equity? Yes__ No__ Unknown__
- p) Any other rights and powers? Please list.

COMPLETE EXPLANATION(S) FOR QUESTIONS a) through p) HERE.

If more space is required, use additional sheets and attach.

(*If you answered "yes" to h), please state below whether a full driving evaluation has been conducted.)

¹ As defined in S.C. Code Ann. § 62-5-101(23), "Supports and assistance" includes:

(a) systems in place for the alleged incapacitated individual to make decisions in advance or to have another person to act on his behalf, including, but not limited to, having an agent under a durable power of attorney, a health care power of attorney, a trustee under a trust, a representative payee to manage social security funds, a Declaration of Desire for Natural Death (living will), a designated health care decision maker under Section 44-66-30, or an educational representative designated under Section 59-33-310 to Section 59-33-370; and

(b) reasonable accommodations that enable the alleged incapacitated individual to act as the principal decision maker, including, but not limited to, using technology and devices; receiving assistance with communication; having additional time and focused discussion to process information; providing tailored information oriented to the comprehension level of the alleged incapacitated individual; and accessing services from community organizations and governmental agencies.

9. Would the patient benefit from:

- a) Therapy or treatment? Yes__ No__
- b) Medical aids or equipment? Yes__ No__
- c) An operation or medical procedure(s)? Yes__ No__
- d) Psychiatric treatment? Yes__ No__

10. Has the patient had in the last six months:

- a) Hospitalization(s)? Yes__ No__
- b) Therapy or treatment? Yes__ No__
- c) Inpatient or outpatient surgery? Yes__ No__
- d) Major medical test(s)? Yes__ No__
- e) Psychological or psychiatric testing? Yes__ No__

11. In your opinion, does the patient have the ability to:

- a) effectively manage his/her property or individual financial affairs, provide for his/her support, or for the support of his/her legal dependents? Yes__ No__

If yes, is the ability limited in any way? Please explain:

- b) meet the essential requirements for his/her physical health, safety, or self-care. Yes__ No__

If yes, is the ability limited in any way? Please explain:

12. The patient continues to perform the following activities of daily living:

13. Does the patient have:

- a) A power of attorney? Yes__ No__ Unknown__
- b) A healthcare power of attorney? Yes__ No__ Unknown__
- c) A "living will"? Yes__ No__ Unknown__

14. Does the patient have any of the following coverages?

- a) Health insurance? Yes__ No__ Unknown__
- b) Medicare? Yes__ No__ Unknown__
- c) Medicaid? Yes__ No__ Unknown__
- d) Veteran's health care? Yes__ No__ Unknown__

15. Does the patient have a primary caregiver? Yes__ No__

If yes, provide caregiver's name, address, and relationship to the patient.

16. Please identify the persons with whom you met or consulted regarding the patient's mental or physical condition:
