RESET

Physician's Evaluation/ Conservatorship
PC-370 REV. 7/16

CONNECTICUT PROBATE COURTS

CONFIDENTIAL

RECEIVED:

Instructions:
1) A Connecticut licensed physician may be requested to complete this form in connection with an involuntary proceeding for the appointment of a conservator of the person or estate, or a review of a conservatorship previously established by the Probate Court. The physician should complete the form only if the physician has personally examined the patient.
2) The contents of this form will be used by the Probate Court in determining whether a patient is capable of self-care or can self-manage financial affairs. If the court finds by clear and convincing evidence that the ability of the patient to receive or evaluate information or make or communicate decisions is impaired, it may appoint a conservator and authorize the conservator to assume the responsibility to manage some or all of the patient's personal or financial affairs. The goal of the report is to highlight mental, physical or emotional conditions with sufficient specificity so the court may determine the precise areas in which a patient's functional limitations, if any, require supervision by a conservator.
3) Type or print the form in ink. Use additional sheets, or PC-180, if more space is needed.

Probate Court Name	**District Number**

Patient

Physician (Name, address and telephone number.)	**Date of Examination** (Month, day, year.) **Place of Examination**
Connecticut Medical License No. Practicing Psychiatrist ☐ Yes ☐ No	Professional Relationship to Patient ☐ Consultation/Evaluation ☐ Treating Physician How long have you treated this patient?

Is the patient's capacity to make financial decisions impaired? ☐ Yes ☐ No

Is the patient's capacity to make personal decisions impaired? ☐ Yes ☐ No

1. If the answer to either question is "yes," please complete all sections below. Please give specific examples of recent history known to you that contribute to your answers below. If more space is required, use additional sheets.

1a. In my opinion, the patient has a ☐ mental illness ☐ cognitive deficiency ☐ physical illness or physical disability ☐ an addiction or ☐ other (specify) _____ that results in the patient being unable to receive or evaluate information or make or communicate decisions about the patient's personal or financial affairs as indicated above.

Patient's Name

1b. Describe the patient's current status or symptoms stemming from this condition.

1c. What is the current medical diagnosis?

1d. Is the current condition transitory or permanent in nature? Explain.

1e. Does the illness or condition affect the patient's ability to seek or obtain medical care? ☐ Yes ☐ No
If "yes," give specific examples.

1f. Does the illness or condition affect the patient's ability to secure and maintain a safe living environment?
☐ Yes ☐ No If "yes," give specific examples.

1g. Does the illness or condition affect the patient's ability to independently manage financial affairs? ☐ Yes ☐ No
If "yes," give specific examples.

1h. Does the illness or condition raise safety concerns, including the patient's ability to seek protection from
☐ physical abuse or harm or ☐ financial exploitation? ☐ Yes ☐ No If "yes," give specific examples.

2. Medications

2a. List all medications prescribed.

Is the patient capable of managing his/her medications? ☐ Yes ☐ No

2b. Do any of these medications impact mental functioning? ☐ Yes ☐ No ☐ Uncertain
If so, how?

Patient's Name

3. Treatments and Interventions

3a. Does the patient require hospitalization or additional medical treatment or intervention? If "yes," please explain.

3b. Is the patient capable of weighing the benefits and risks of the medical treatment or other alternative interventions recommended in 3a. above? Please explain.

4. Additional information

Include any other relevant information you believe should be presented to the court.

5. Review of conservatorship

If this form was requested in conjunction with a review of the conservatorship under C.G.S. section 45a-660, please also complete this section.

In my opinion, the conservatorship should be ☐ continued ☐ modified ☐ terminated. Specify your reasons for your opinion. **If more space is required, use additional sheets.**

I hereby certify that I am a licensed physician, and I personally examined the patient on the above-referenced date.

Signature
Type or print name
Date