(Copy Receipt) (Clerk's Date Stamp)

SUPERIOR COURT OF WASHINGTON COUNTY OF SPOKANE

In the Guardianship of:	CASE NO. _____
_____	MEDICAL/PSYCHOLOGICAL REPORT
	(MDR)

This form is required by Washington state law for all Guardianships. Your assistance in completing this form on or before _____ is appreciated. (Please type or print clearly.)

I have been chosen by the Guardian ad Litem in the above matter to examine and interview _____, and I submit the following report:

_____.

A. My name, title, address, telephone number are as follows: _____

_____

_____.

B. My education and experiences that are pertinent to the type of disorder or incapacity involved in this case are as follows: (*a resume/curriculum vitae may be attached.*) _____

_____

_____.

C. Date of most recent examination of the Alleged Incapacitated Person (most recent exam must be within 30 days of date of this request): _____.

D. A summary of the relevant medical, functional, neurological, psychological, or psychiatric history of the Alleged Incapacitated Person as known to me is as follows:

_____

_____.

E. My findings as to the Alleged Incapacitated Person as it relates to capacity to manage personal or financial matters are: _____

_____.

F. The following medication(s) are currently prescribed to the Alleged Incapacitated Person for the following condition(s).

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Medication: _____ Condition: _____

G. The effect of these current medications on the Alleged Incapacitated Person's ability to understand or participate in the Guardianship proceedings is: _____

_____.

H. My opinion as to the specific assistance the Alleged Incapacitated Person needs is (*including items such as household chores, managing finances*): _____

_____

_____.

I. I have also met or spoken with the following individuals regarding the Alleged Incapacitated Person: _____.

I certify (or declare) under penalty of perjury under the laws of the State of Washington that to the best of my knowledge the statements above are true and correct.

SIGNED AT _____, WASHINGTON THIS _____ DAY OF _____, 20_____

Signature of Physician/Psychologist/ Advanced Registered Nurse Practitioner	Printed Name of Physician/Psychologist/ Advanced Registered Nurse Practitioner

Address	City, State, Zip Code
Telephone/Fax Number	Email Address