**IN THE CIRCUIT COURT**
**TWENTY-FOURTH JUDICIAL CIRCUIT**
**_____ COUNTY, ILLINOIS**

| | | |
|---|---|---|
| IN THE MATTER OF THE GUARDIANSHIP OF: | ] | |
| | ] | No: _____ |
| _____ | ] | |
| A PERSON ALLEGED TO HAVE A DISABILITY. | ] | |

**PHYSICIAN'S REPORT**

This report is requested for the purpose of determining whether a guardianship for your patient should be pursued. Chapter 740 Illinois Compiled Statutes 110/10 allows for the disclosure of otherwise confidential information to determine whether a guardianship is needed.

Patient's Name: _____ DOB: _____

Physician's Name: _____

Physician's Address
City: State: Zip:

_____ _____ _____

Physician's Telephone Number: _____

Date of Last Examination of Patient: _____

Description of the nature and type of patient's disability:

Assessment of how the disability impacts on the ability of the patient to make decisions or to function independently:

An analysis and results of evaluations of the patient's mental and physical condition and, where appropriate, educational condition, adaptive behavior and social skills, which have been performed within the past three months:

Do you believe a full/plenary and permanent guardianship is needed for this patient?

☐ YES

☐ NO

If no, do you believe a limited guardianship is needed for this patient?

☐ YES

☐ NO

Please state the reasons for your recommendation:

What is your recommendation as to the most suitable living arrangement of this patient and, where appropriate, treatment or habilitation plan for the patient and the reasons therefore:

Date of this report

Physician's Signature

Signature(s) of all persons who performed the evaluations upon which the report is based:

Signature

Printed Name

Signature

Printed Name

Signature

Printed Name

Statement of certification, license, or other credentials that qualify the evaluators who prepared the report:

Print

Clear Form