Ward Name: Case Number:

Annual Physician's Report of Examination (All items must be answered)	
1	Diagnosis:
2	Recommended Treatment:
3	Prognosis:
4	The current level of capacity of the patient is:
5	In your opinion, is the patient capable of exercising the following?(Use checkboxes Below Right to marry: ☐ Yes ☐ No Right to vote: ☐ Yes ☐ No Right to personally apply for government benefits: ☐ Yes ☐ No Right to have a driver's license: ☐ Yes ☐ No Right to travel: ☐ Yes ☐ No Right to seek or retain employment: ☐ Yes ☐ No Right to contract: ☐ Yes ☐ No Right to sue and be sued: ☐ Yes ☐ No Right to manage property or to make any give of disposition: ☐ Yes ☐ No Right to determine residence: ☐ Yes ☐ No Right to consent to medical treatment: ☐ Yes ☐ No Right to make decisions about social environment or social aspects: ☐ Yes ☐ No
6	Date of Examination:

Doctor Signature

Type/Print Doctor Name

Doctor Address (Street Address, City, State, Zip)

Date of Doctor's Signature