

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: <input type="checkbox"/> Yes <input type="checkbox"/> No Right to vote: <input type="checkbox"/> Yes <input type="checkbox"/> No Right to personally apply for government benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No Right to have a driver's license: <input type="checkbox"/> Yes <input type="checkbox"/> No Right to travel: <input type="checkbox"/> Yes <input type="checkbox"/> No Right to seek or retain employment: <input type="checkbox"/> Yes <input type="checkbox"/> No Right to contract: <input type="checkbox"/> Yes <input type="checkbox"/> No Right to sue and be sued: <input type="checkbox"/> Yes <input type="checkbox"/> No Right to manage property or to make any give of disposition: <input type="checkbox"/> Yes <input type="checkbox"/> No Right to determine residence: <input type="checkbox"/> Yes <input type="checkbox"/> No Right to consent to medical treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No Right to make decisions about social environment or social aspects: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6 | Date of Examination: |

Doctor Signature

Type/Print Doctor Name

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

Date of Doctor's Signature