



CIRCUIT COURT FOR \_\_\_\_\_, MARYLAND

City/County

Located at \_\_\_\_\_ Case No. \_\_\_\_\_

Court Address

In the Matter of \_\_\_\_\_

Name of Alleged Disabled Person

Docket Reference

LICENSED CERTIFIED SOCIAL WORKER-CLINICAL (LCSW-C)
CERTIFICATE (Md. Rule 10-202(a)(2))

NOTE TO LICENSED CERTIFIED SOCIAL WORKER-CLINICAL (LCSW-C): A petitioner will use this certificate in a legal proceeding to request a guardian for the patient named below. The petitioner must submit the original certificate. Your answers must be specific and detailed and based on your personal evaluation of the patient. Address each issue contained in the certificate that may interfere with the patient's ability to make responsible decisions about health care, food, clothing, shelter, or property. You may complete the form yourself or have another person complete it under your supervision. Attach additional sheets, if necessary. Your testimony about this information may be required at a hearing.

PATIENT'S NAME: \_\_\_\_\_

PATIENT'S ADDRESS: \_\_\_\_\_

I, \_\_\_\_\_ LCSW-C's Name

Address

\_\_\_\_\_, am a \_\_\_\_\_ Year graduate of \_\_\_\_\_ School
Telephone Number

I am licensed in the United States in the following state(s): \_\_\_\_\_

My license number is \_\_\_\_\_ My specialty is \_\_\_\_\_

I have known this patient for \_\_\_\_\_ Length of Time . My history of involvement with the patient is as follows:

Empty rectangular box for history of involvement.

Evaluation and Diagnosis

I personally evaluated the above-named patient on \_\_\_\_\_ Date(s)

(include date of most recent evaluation, as well as any other relevant visits). The most recent

evaluation lasted approximately \_\_\_\_\_ Length of Time . I performed or ordered the following tests and/or

procedures: \_\_\_\_\_

I communicated with the patient in the following manner:

English

Other language or means (explain): .....

Upon examination of the patient, I report the following findings:

**PHYSICAL AND MENTAL CONDITIONS**

**Physical conditions**

None

The patient has the following physical diagnoses:

.....  
.....

Overall physical health:  Excellent  Good  Fair  Poor

Explain:

.....  
.....

Overall physical health will:  Improve  Be stable  Decline  Uncertain

Explain:

.....  
.....

**Mental conditions**

None

The patient has the following mental (DSM) diagnoses:

Axis I.

Mild  Moderate  Severe

Axis II.

Mild  Moderate  Severe

Other:

.....  
.....

Mild  Moderate  Severe

Overall mental health will:  Improve  Be stable  Decline  Uncertain

If improvement is possible, the individual should be re-evaluated in \_\_\_\_\_ weeks.

The mental diagnosis/diagnoses affect functioning as follows:

.....  
.....  
.....

Have any temporary causes of mental impairment been evaluated and treated (e.g., depression, bereavement, or delirium)?  Yes  No  Uncertain

Explain:

.....  
.....

Have any reversible causes of mental impairment been evaluated and treated (e.g., coma)?

Yes  No  Uncertain

Explain:

.....  
.....

**List all medications:**

<u>Name</u>	<u>Purpose</u>	<u>Dosage/Schedule</u>
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

**Reversible or temporary somatic factors**

Are there factors (e.g., hearing, vision or speech impairment, etc.) that incapacitate the patient that could improve with time, treatment, or assistive devices?

Yes  No  Uncertain

Explain:

.....  
.....

**COGNITIVE FUNCTION**

**Alertness/level of consciousness**

Overall impairment:  None  Mild  Moderate  Severe  Non-responsive

Describe below or  in attachment

.....  
.....

**Memory, cognitive, and executive functioning**

Overall impairment:  None  Mild  Moderate  Severe  Non-responsive

Describe below or  in attachment

.....  
.....

**Fluctuation**

Symptoms vary in frequency, severity, or duration:  Yes  No  Uncertain

Describe below or  in attachment

**EVERYDAY FUNCTIONING**

The patient is **capable** of performing the Instrumental Activities of Daily Living (IADLs) (select all that apply):

- Managing finances effectively
- Managing transportation needs
- Managing communication (e.g., telephone and mail)
- Managing medication
- Other executive functions (describe):

The patient is **capable** of participating in the following civil or legal matters (select all that apply):

- Signing documents
- Retaining legal counsel
- Participating in legal proceedings
- Other (describe):

**Need for Guardian of Person**

In my professional opinion, within a reasonable degree of certainty within the social work profession, the patient has a disability which (**select one**)  does  does not prevent him/her from making or communicating **any** responsible decisions concerning his/her **person**.

**OR**

In my professional opinion, within a reasonable degree of certainty within the social work profession, the patient has a disability which (**select one**)  does  does not prevent him/her from making or communicating **some** responsible decisions concerning his/her **person**. The patient, for example, is able to make decisions regarding:

but is unable to make decisions regarding:

**Need for Guardian of Property**

In my professional opinion, within a reasonable degree of certainty within the social work profession, the patient has a disability which **(select one)**  does  does not prevent him/her from making or communicating **any** responsible decisions concerning his/her **property** and has a demonstrated inability to manage his/her **property** and affairs effectively because of physical or mental disability.

OR

In my professional opinion, within a reasonable degree of certainty within the social work profession, the patient has a disability which **(select one)**  does  does not prevent him/her from making or communicating **some** responsible decisions concerning his/her **property**. The patient, for example, is able to make decisions regarding:

.....  
.....  
.....

but is unable to make decisions regarding:

.....  
.....  
.....

**I solemnly affirm under the penalties of perjury that the contents of this document are true to the best of my knowledge, information, and belief.**

.....  
Date

.....  
LCSW-C's Signature

.....  
Printed Name

