

### **INSTRUCTIONS FOR SUBMITTING AN EXPERT REPORT**

To establish incapacity, the petitioner must present testimony from an individual qualified by training and experience in evaluating persons with incapacities of the type alleged by the petitioner. As an accommodation to such expert witnesses, the court may accept a complete and legible expert report in accordance with the attached form in lieu of expert testimony, whether in person or by deposition, unless otherwise required by rule or order of court.

COURT OF COMMON PLEAS OF  
\_\_\_\_\_ COUNTY PENNSYLVANIA  
ORPHANS' COURT DIVISION

**EXPERT REPORT**

RE: \_\_\_\_\_  
*An Alleged Incapacitated Person (AIP)*

No. \_\_\_\_\_

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**PART I: PROFESSIONAL BACKGROUND** (You may attach your curriculum vitae, if it provides answers to Questions 1 through 5. Please answer those questions not covered by curriculum vitae.)

1. Name: \_\_\_\_\_ Title: \_\_\_\_\_

2. Professional Address: \_\_\_\_\_

3. Complete education information:

	Name of Institution	Type of Degree Received	Date Completed
Undergraduate			
Graduate			
Post-Graduate			

4. Do you have any active professional licenses?  Yes  No  
If **yes**, indicate in what state or states you are licensed as well as the date(s) issued.

\_\_\_\_\_  
\_\_\_\_\_

List any board certifications: \_\_\_\_\_

5. An Incapacitated Person is legally defined as: An adult whose ability to receive and evaluate information effectively and communicate decisions in any way is impaired to such a significant extent that he/she is partially or totally unable to manage his/her financial resources or to meet essential requirements for his/her physical health and safety.

Do you have experience evaluating whether or not an individual is incapacitated?  Yes  No

If **yes**, indicate the basis of your experience:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART II: ALLEGED INCAPACITATED PERSON (AIP)**

6. a. Have you treated, assessed, or evaluated the AIP?

Yes     No

b. Indicate the date(s) and location of any treatment, assessment, or evaluation you have provided or made over the last two (2) years:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

c. If 6a. is yes, what tests have you or others administered, e.g., mini mental status exam (MMSE), Montreal Cognitive Assessment (MOCA), St. Louis University Mental Status Exam (SLUMS), etc.? List dates administered and the score. (Attach test results, not just the score.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. What is the present condition of the AIP? List all known medical and psychiatric diagnoses and current symptoms. (You may attach a list from your records.)

<u>Diagnosis</u>	<u>Symptoms/Manifestations</u>

8. List all known medications, including over-the-counter, that the AIP is taking. For each known medication, indicate, if known, the prescribing physician and the diagnosis for which the medication was prescribed or the reason for taking. (You may attach a list from your records.)

<u>Medication</u>	<u>Diagnosis/Reason Taken</u>	<u>Prescribing Physician</u>

9. Indicate the AIP's ability to perform the following functions:

	Unimpaired	Needs Some Help (Explain in #10 )	Totally Impaired	Not Assessed or Not Enough Information
Receiving and evaluating information effectively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicating decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to give informed consent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short-term memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long-term memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Activities of daily living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing finances (including paying bills, making deposits, withdrawals and working with financial institutions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing health care (including following doctor's orders and managing/taking medications)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Providing for physical safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Responding to emergency situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to resist scams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. For any response in Question 9 where the AIP "needs some help," please describe the type and extent of assistance needed.

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11. What recommendations have you made or would you make concerning services necessary to meet the essential requirements for the AIP's physical health and safety?

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12. What recommendations have you made or would you make concerning management of the AIP's finances?

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13. As indicated in Question 5, an Incapacitated Person is legally defined as: An adult whose ability to receive and evaluate information effectively and communicate decisions in any way is impaired to such a significant extent that he/she is partially or totally unable to manage his/her financial resources or to meet essential requirements for his/her physical health and safety.

In your expert opinion, within a reasonable degree of professional certainty and based on your knowledge, skills, experience, and education, is the AIP incapacitated?

- Yes, totally impaired       Yes, partially impaired       No

14. In your opinion, the most appropriate, least restrictive living situation for the AIP is (check one):

- The AIP can be left alone without supervision  
 Home (  with part-time home health aide or  24/7 assistance)  
 Independent living facility (room and board provided, emergency services readily available)  
 Assisted living facility (room and board provided, assistance with some activities of daily living)  
 Secure facility (Alzheimer's/Mental Health for safety and basic needs)  
 Skilled nursing facility

15. If your responses in Question 9 indicated that the AIP is totally impaired or "needs some help", do you expect the AIP's abilities in the next 6 months to (Check best estimate):

- Stay the same       Improve       Decline

Please explain:

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### PART III: GUARDIANSHIP AND SERVICES

16. Are you aware of any circumstances, medical or otherwise, that create a need for the appointment of an emergency guardian for the AIP?

- Yes       No

If yes, indicate reasons:

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17. The AIP is required to be at the hearing, absent circumstances that could cause harm to the AIP. Putting aside whether the court proceeding may be moderately upsetting to, confusing to or not understood by the AIP, do you believe that the AIP's presence at the hearing would cause harm to the AIP's physical or mental condition?

Yes       No

Indicate reason for response:

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18. Please provide any additional information that could assist the court in determining incapacity.

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I verify that the foregoing information is correct to the best of my knowledge, information and belief; and that this verification is subject to the penalties of 18 Pa.C.S. § 4904 relative to unsworn falsification to authorities.

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Name (type or print)*

\_\_\_\_\_  
*Address*

\_\_\_\_\_  
*City, State, Zip*

\_\_\_\_\_  
*Telephone*

\_\_\_\_\_  
*Email*