SAMPLE PHYSICIAN'S AFFIDAVIT **(Brain Injury)**

NOTE: This affidavit will be used in a legal proceeding to appoint a guardian for the patient named below. Detailed information is necessary for the court to assess whether the patient has a disability under Delaware law. A person with a disability is defined under Delaware law as someone who "[b]y reason of mental or physical incapacity is unable properly to manage or care for their own person or property, or both, and, in consequence thereof, is in danger of dissipating or losing such property or of becoming the victim of designing persons or, in the case where a guardian of the person is sought, such person is in danger of substantially endangering person's own health, or of becoming subject to abuse by other persons or of becoming the victim of designing persons[.]" 12 Del. C. § 3901(a)(2). The information in this affidavit must be specific and detailed and based on your personal examination of the patient. By completing this form, you consent to make reasonable accommodations to speak to the court appointed attorney *ad litem* should they need to speak to you regarding the statements you made in this affidavit. Sample forms are available on the court's website at https://courts.delaware.gov/forms/. Thank you for your concern and cooperation.

IS THIS AN EMERGENCY GUARDIANSHIP PETITION? If an ***emergency*** appointment of guardian is needed, please complete page four (4) of this form *in addition* to pages one (1) through three (3).

PATIENT'S NAME: John Smith

ADDRESS: 1000 Delaware Avenue, Georgetown, DE 19947

DATE OF BIRTH: February 21, 2001

I, Dr. James Montgomery, (check one) ☐M.D., ☒D.O., ☐Ph.D., ☐Psy.D., of full age, hereby certify as follows:

I am duly licensed and accredited in the following areas of medical practice:

Delaware and Maryland

Internal Medicine

The history of my involvement with this patient is the following: (check the appropriate box(es) and add further clarification on the blank lines)

☐ 10+ years ☐ 5-10 years ☐ 1-5 years ☒ Less than 1 year ☐ First visit

Attending physician at the Facility. Primary Care Physician/Provider

The patient's diagnoses/conditions related to their incapacity include:

1. Anoxic/Traumatic Brain Injury ☐ Mild ☐ Moderate ☒ Severe ☐ N/A
2. Encephalopathy ☐ Mild ☐ Moderate ☒ Severe ☐ N/A

Patient Name: John Smith

I personally examined this patient on March 1, 2022

The examination lasted approximately 30 minutes
(Time)

Relevant tests and results related to their incapacity: Computerized Tomography (CT Scan), Magnetic Resonance Imaging (MRI), Reviewed Labs, Physical Examination, reviewed medical records, and Mini Mental State Exam (MMSE)

Does the patient have difficulty communicating? If so, describe the difficulty in detail, and provide the cause of the patient's difficulty with communication:

Yes, Non-Verbal

Based on tests and my examination of this patient, it is my professional opinion that she/he:

☐ **does not have**

☒ **does have**

a disability that significantly interferes with the ability to make responsible decisions regarding health care, food, clothing, shelter, or finances.

☐ (Optional) The following documents are attached as supporting information regarding the particulars of the disability:

Describe the patient's disability:
Severe Anoxic Brain Injury, Non-Verbal Communication, Impaired cognition, convulsions, seizures. Severe Encephalopathy

The disability impairs the patient's ability to perform the following functions and activities:
Patient needs assistance with daily living activities (ADL's), including bathing, clothing, feeding, medication and financial decisions

In my opinion, the patient

☐ **does have**

☒ **does not have**

sufficient mental capacity to understand the nature of guardianship in order to consent to the appointment of a guardian.

Patient Name: John Smith

The patient is or is not able to perform the following functions independently:

Activities of daily living	☐ Is able	☒ Is not able
Pay his/her own bills	☐ Is able	☒ Is not able
Live alone	☐ Is able	☒ Is not able
Take medication appropriately	☐ Is able	☒ Is not able
Give informed consent for medical procedures	☐ Is able	☒ Is not able
Resist scams	☐ Is able	☒ Is not able

I solemnly swear and affirm under the penalties of perjury and upon personal knowledge that the contents of this affidavit are true.

_____ _____

Date Physician's Signature

_____

Printed Name

Physician's Address: Sussex Memorial Hospital, 10 Beech Nut Avenue, Milford, DE

Physician's Phone Number: (302) 444-4242

STATE OF _____:

COUNTY OF _____:

This instrument was acknowledged before me on this _____ day of _____, 20_____ by _____ [Name of affiant].

_____

Notary Public

SAMPLE PHYSICIAN'S AFFIDAVIT **(Dementia)**

NOTE: This affidavit will be used in a legal proceeding to appoint a guardian for the patient named below. Detailed information is necessary for the court to assess whether the patient has a disability under Delaware law. A person with a disability is defined under Delaware law as someone who "[b]y reason of mental or physical incapacity is unable properly to manage or care for their own person or property, or both, and, in consequence thereof, is in danger of dissipating or losing such property or of becoming the victim of designing persons or, in the case where a guardian of the person is sought, such person is in danger of substantially endangering person's own health, or of becoming subject to abuse by other persons or of becoming the victim of designing persons[.]" 12 Del. C. § 3901(a)(2). The information in this affidavit must be specific and detailed and based on your personal examination of the patient. By completing this form, you consent to make reasonable accommodations to speak to the court appointed attorney *ad litem* should they need to speak to you regarding the statements you made in this affidavit. Sample forms are available on the court's website at https://courts.delaware.gov/forms/. Thank you for your concern and cooperation.

IS THIS AN EMERGENCY GUARDIANSHIP PETITION? If an ***emergency*** appointment of guardian is needed, please complete page four (4) of this form *in addition* to pages one (1) through three (3).

PATIENT'S NAME: Luke Spencer

ADDRESS: 500 N. 100th Street, Wilmington, DE 19713

DATE OF BIRTH: May 15, 1935

I, Dr. Roman Brady, (check one) ☒M.D., ☐D.O., ☐Ph.D., ☐Psy.D., of full age, hereby certify as follows:

I am duly licensed and accredited in the following areas of medical practice:

Delaware and Texas – Family Medicine and Internal Medicine

The history of my involvement with this patient is the following: (check the appropriate box(es) and add further clarification on the blank lines)

☐ 10+ years ☐ 5-10 years ☒ 1-5 years ☐ Less than 1 year ☐ First visit

I am attending physician – Primary Care Physician

The patient's diagnoses/conditions related to their incapacity include:

1. Alzheimer and Dementia ☐ Mild ☐ Moderate ☒ Severe ☐ N/A
2. Diabetes ☐ Mild ☒ Moderate ☐ Severe ☐ N/A

Patient Name: Luke Spencer

I personally examined this patient on: March 1, 2022

The examination lasted approximately 20 minutes
(Time)

Relevant tests and results related to their incapacity:

Physical Examination, reviewed labs, CT Scan (Head)

Mini Mental State Exam – MMSE – 10/30 score

(The maximum MMSE score is **30 points**. A Score of **20-24** suggest mild dementia, **13 to 20** suggests moderate dementia, and **less than 12** indicates severe dementia. On average the MMSE score of a person with Alzheimer's declines about two to four points each year.)

Does the patient have difficulty communicating? If so, describe the difficulty in detail, and provide the cause of the patient's difficulty with communication:
Patient has trouble finding the right words, repeats words, stories and phrases, mixes unrelated phrases and ideas, loses train of thought easily

Based on tests and my examination of this patient, it is my professional opinion that she/he:

☐ **does not have**

☒ **does have**

a disability that significantly interferes with the ability to make responsible decisions regarding health care, food, clothing, shelter, or finances.

☐ (Optional) The following documents are attached as supporting information regarding the particulars of the disability:
MMSE Exam

Describe the patient's disability:
Alzheimer's Dementia Disease - Visual Variant – Severe, End states of Dementia
Apraxia

The disability impairs the patient's ability to perform the following functions and activities:
Needs aid with daily activities of daily living such as clothing, feeding bathing medication, preparing meals and when to eat, cannot handle own finances, unable to drive

Patient Name: Luke Spencer

In my opinion, the patient

☐ **does have**

☒ **does not have**

sufficient mental capacity to understand the nature of guardianship in order to consent to the appointment of a guardian.

The patient is or is not able to perform the following functions independently:

Activities of daily living	☐ Is able	☒ Is not able
Pay his/her own bills	☐ Is able	☒ Is not able
Live alone	☐ Is able	☒ Is not able
Take medication appropriately	☐ Is able	☒ Is not able
Give informed consent for medical procedures	☐ Is able	☒ Is not able
Resist scams	☐ Is able	☒ Is not able

I solemnly swear and affirm under the penalties of perjury and upon personal knowledge that the contents of this affidavit are true.

_____ _____

Date Physician's Signature

_____

Printed Name

Physician's Address: 499 Oogleston Stanton Road, Newark, DE 19713

Physician's Phone Number: (302) 999-9999

STATE OF _____:

COUNTY OF _____:

This instrument was acknowledged before me on this _____ day of _____, 20_____ by _____ [Name of affiant].

_____

Notary Public

SAMPLE PHYSICIAN'S AFFIDAVIT **(Autism)**

NOTE: This affidavit will be used in a legal proceeding to appoint a guardian for the patient named below. Detailed information is necessary for the court to assess whether the patient has a disability under Delaware law. A person with a disability is defined under Delaware law as someone who "[b]y reason of mental or physical incapacity is unable properly to manage or care for their own person or property, or both, and, in consequence thereof, is in danger of dissipating or losing such property or of becoming the victim of designing persons or, in the case where a guardian of the person is sought, such person is in danger of substantially endangering person's own health, or of becoming subject to abuse by other persons or of becoming the victim of designing persons[.]" 12 Del. C. § 3901(a)(2). The information in this affidavit must be specific and detailed and based on your personal examination of the patient. By completing this form, you consent to make reasonable accommodations to speak to the court appointed attorney *ad litem* should they need to speak to you regarding the statements you made in this affidavit. Sample forms are available on the court's website at https://courts.delaware.gov/forms/. Thank you for your concern and cooperation.

IS THIS AN EMERGENCY GUARDIANSHIP PETITION? If an ***emergency*** appointment of guardian is needed, please complete page four (4) of this form *in addition* to pages one (1) through three (3).

PATIENT'S NAME: Suzy Ann Jones

ADDRESS: 8888 Berry Lane, Milford, DE 19963

DATE OF BIRTH: 03/03/2001

I, Chase Newman, (check one) ☒M.D., ☐D.O., ☐Ph.D., ☐Psy.D., of full age, hereby certify as follows:

I am duly licensed and accredited in the following areas of medical practice:

Pediatric and Internal Medicine

The history of my involvement with this patient is the following: (check the appropriate box(es) and add further clarification on the blank lines)

☒ 10+ years ☐ 5-10 years ☐ 1-5 years ☐ Less than 1 year ☐ First visit

Primary Care Physician since 2000

The patient's diagnoses/conditions related to their incapacity include:

1. Autism Spectrum Disorder ☐ Mild ☐ Moderate ☒ Severe ☐ N/A
2. Cerebral Palsy ☐ Mild ☒ Moderate ☐ Severe ☐ N/A
3. _____ ☐ Mild ☐ Moderate ☐ Severe ☐ N/A

Patient Name: Suzy Ann Jones

I personally examined this patient on March 2, 2022

The examination lasted approximately __ 30 Minutes
(Time)

Relevant tests and results related to their incapacity:

Reviewed labs, MRI, CT Scan

Does the patient have difficulty communicating? If so, describe the difficulty in detail, and provide the cause of the patient's difficulty with communication:

Communication is limited due to speech is minimal, reasoning, judgment and speech is 1-2 words

Based on tests and my examination of this patient, it is my professional opinion that she/he:

☐ **does not have**

☒ **does have**

a disability that significantly interferes with the ability to make responsible decisions regarding health care, food, clothing, shelter, or finances.

☐ (Optional) The following documents are attached as supporting information regarding the particulars of the disability:

Describe the patient's disability:
Severe Autism, Intellectual Aggressive Behavior, self-injury, Global Developmental Delay, Severe Intellectual Disability, Non-Verbal, Intractable Seizure Disorder, Angelman Syndrome

The disability impairs the patient's ability to perform the following functions and activities:
She needs assistance with daily living activities, bathing, clothing, feeding and requires maximum assistance with all ADL's and total care

In my opinion, the patient

☐ **does have**

☒ **does not have**

sufficient mental capacity to understand the nature of guardianship in order to consent to the appointment of a guardian.

Patient Name: Suzy Ann Jones

The patient is or is not able to perform the following functions independently:

Activities of daily living	☐ Is able	☒ Is not able
Pay his/her own bills	☐ Is able	☒ Is not able
Live alone	☐ Is able	☒ Is not able
Take medication appropriately	☐ Is able	☒ Is not able
Give informed consent for medical procedures	☐ Is able	☒ Is not able
Resist scams	☐ Is able	☒ Is not able

I solemnly swear and affirm under the penalties of perjury and upon personal knowledge that the contents of this affidavit are true.

_____ _____

Date Physician's Signature

_____

Printed Name

Physician's Address: 1001 My Little Pony Road, Milford, DE 19963

Physician's Phone Number: (302) 898-9999

STATE OF _____:

COUNTY OF _____:

This instrument was acknowledged before me on this _____ day of _____, 20_____ by _____ [Name of affiant].

_____

Notary Public

SAMPLE PHYSICIAN'S AFFIDAVIT **(Schizoaffective and Bi-Polar Disorder)**

NOTE: This affidavit will be used in a legal proceeding to appoint a guardian for the patient named below. Detailed information is necessary for the court to assess whether the patient has a disability under Delaware law. A person with a disability is defined under Delaware law as someone who "[b]y reason of mental or physical incapacity is unable properly to manage or care for their own person or property, or both, and, in consequence thereof, is in danger of dissipating or losing such property or of becoming the victim of designing persons or, in the case where a guardian of the person is sought, such person is in danger of substantially endangering person's own health, or of becoming subject to abuse by other persons or of becoming the victim of designing persons[.]" 12 Del. C. § 3901(a)(2). The information in this affidavit must be specific and detailed and based on your personal examination of the patient. By completing this form, you consent to make reasonable accommodations to speak to the court appointed attorney *ad litem* should they need to speak to you regarding the statements you made in this affidavit. Sample forms are available on the court's website at https://courts.delaware.gov/forms/. Thank you for your concern and cooperation.

IS THIS AN EMERGENCY GUARDIANSHIP PETITION? If an ***emergency*** appointment of guardian is needed, please complete page four (4) of this form *in addition* to pages one (1) through three (3).

PATIENT'S NAME: Erika Boulevard

ADDRESS: 10910 New England Street, Smyrna, DE 19977

DATE OF BIRTH: 10/10/1990

I, Dr. Rick Bauer, (check one) ☒M.D., ☐D.O., ☐Ph.D., ☒Psy.D., of full age, hereby certify as follows:

I am duly licensed and accredited in the following areas of medical practice:

Medical Doctor and Psychiatry Licensed in Delaware and Pennsylvania

The history of my involvement with this patient is the following: (check the appropriate box(es) and add further clarification on the blank lines)

☐ 10+ years ☐ 5-10 years ☐ 1-5 years ☐ Less than 1 year ☒ First visit

Inpatient Psychiatrist

The patient's diagnoses/conditions related to their incapacity include:

1. Schizoaffective Disorder ☐ Mild ☐ Moderate ☒ Severe ☐ N/A
2. Bi-Polar Type ☐ Mild ☒ Moderate ☐ Severe ☐ N/A
3. Depression ☐ Mild ☐ Moderate ☒ Severe ☐ N/A

Patient Name: Erika Boulevard

I personally examined this patient on March 1, 2022

The examination lasted approximately 30 minutes
(Time)

Relevant tests and results related to their incapacity:

MRI, EKG, Blood Test, Urine Analysis

Does the patient have difficulty communicating? If so, describe the difficulty in detail, and provide the cause of the patient's difficulty with communication:

Based on tests and my examination of this patient, it is my professional opinion that she/he:

☐ **does not have**

☒ **does have**

a disability that significantly interferes with the ability to make responsible decisions regarding health care, food, clothing, shelter, or finances.

☐ (Optional) The following documents are attached as supporting information regarding the particulars of the disability:

Describe the patient's disability:
Severe Chronic Psychosis Auditing Hallucinations and Paranoia

The disability impairs the patient's ability to perform the following functions and activities:

Needs assistance with all ADL's and Manage Medication

In my opinion, the patient

☐ **does have**

☒ **does not have**

sufficient mental capacity to understand the nature of guardianship in order to consent to the appointment of a guardian.

Patient Name: Erika Boulevard

The patient is or is not able to perform the following functions independently:

Activities of daily living	☐ Is able	☒ Is not able
Pay his/her own bills	☒ Is able	☐ Is not able
Live alone	☐ Is able	☒ Is not able
Take medication appropriately	☐ Is able	☒ Is not able
Give informed consent for medical procedures	☐ Is able	☒ Is not able
Resist scams	☐ Is able	☒ Is not able

I solemnly swear and affirm under the penalties of perjury and upon personal knowledge that the contents of this affidavit are true.

_____ _____

Date Physician's Signature

_____

Printed Name

Physician's Address: St. James Facility, 1976 Liberty Lane, Dover, DE

Physician's Phone Number: (302) 743-0002

STATE OF _____:

COUNTY OF _____:

This instrument was acknowledged before me on this _____ day of _____, 20_____ by _____ [Name of affiant].

_____

Notary Public