# PHYSICIAN'S AFFIDAVIT

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: _____

ADDRESS: _____

DATE OF BIRTH: _____

I, _____, (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: _____
_____

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

_____
_____

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

1. _____ ☐ Mild ☐ Moderate ☐ Severe ☐ N/A
2. _____ ☐ Mild ☐ Moderate ☐ Severe ☐ N/A
3. _____ ☐ Mild ☐ Moderate ☐ Severe ☐ N/A

Patient Name: _____

I personally examined this patient on _____, 20_____.

The examination lasted approximately _____
(Time)

Relevant tests and results related to their incapacity:

_____
_____
_____
_____

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:

_____
_____
_____

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

_____
_____

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: _____

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: _____

Physician's Phone Number: _____

STATE OF _____:

COUNTY OF _____:

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

_____

Notary Public

Patient Name: _____

**TO BE COMPLETED WHEN REQUESTING AN EMERGENCY GUARDIANSHIP OF THE PERSON**

Nature of the emergency, such as medical, abuse, neglect, exploitation, etc.: _____
_____
_____

If this is a medical emergency, provide the diagnosis: _____
_____
_____

Describe the testing or treatment related to the diagnosis that is urgently needed and cannot be accomplished without imposition of a guardianship and why it is urgently needed within the next 72 hours: _____
_____
_____

Do you recommend a change in the code status at this time? ☐ Yes ☐ No
Do you recommend withdrawal of treatment at this time? ☐ Yes ☐ No

If you responded "Yes" to either of the above, please respond to the following:

What is the current code in the patient's file? ☐ Full code ☐ DNR ☐ Other _____
Is there a living will in the patient's file? ☐ Yes ☐ No
If yes, please attach a copy.
Have you spoken with the patient about their end of life wishes? ☐ Yes ☐ No
If "Yes", what are their wishes and how you know what their wishes are
_____
_____
_____

_____ _____
Date Physician's Signature

_____
Printed Name

STATE OF _____:

COUNTY OF _____:

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

_____
Notary Public

*Form CM2*
*Rev. 05/2024*