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: ____

Patient's address: ____

Patient's 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_______ (patient must have been seen within the last 3 months).

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

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

☐ **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:

Function	The patient can perform independently	The patient cannot perform 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 printed name: ____

Physician's signature: ____

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. The court will not grant a change of code against the patient's existing living will without clear and convincing evidence that the patient would choose withdrawal of life-sustaining treatment.

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 printed name: ____

Physician's signature: ____

STATE OF ___________________________:

COUNTY OF _________________________:

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

____
Notary Public

Form CM2
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