

**Instructions for completing the Report of Physician form:**

Please complete the included form legibly. Each question must have an answer that contains clear and convincing information regarding the specific issues the physician believes are relevant.

**Once completed you must send both a copy of the form to us *AND* the original itself.**

**Where to send a copy of this form:**

Copies should be sent to our offices immediately via fax or email  
at: (520) 624-7190 or [GCD.Referrals@pima.gov](mailto:GCD.Referrals@pima.gov)

**Where to send the original form:**

The original document **MUST** be sent via U.S. Mail to:

Pima County Public Fiduciary

Attn: Intake Unit

32 N. Stone Ave., 4<sup>th</sup> Floor

Tucson, AZ 85701

If you have any questions regarding this form, or how to complete it, please call 724-5454 and ask for the intake unit.

1 **PIMA COUNTY PUBLIC FIDUCIARY**  
32 N. Stone Avenue, 4<sup>th</sup> Floor  
2 Tucson, Arizona 85701  
520-724-5454  
3 FAX 520-624-7190

4 Public.Fiduciary@pima.gov  
License #20247  
5

6 **IN THE SUPERIOR COURT OF THE STATE OF ARIZONA**  
7 **IN AND FOR THE COUNTY OF PIMA**

8 In the Matter of the Guardianship  
9 of:

No.

REPORT OF PHYSICIAN

10 DOB:

11 An Adult Incapacitated Person.

12 \_\_\_\_\_ a physician, a  
13 psychologist, a registered nurse (circle one) licensed to  
14 practice in the State of Arizona, submits the following report  
15 concerning \_\_\_\_\_, an alleged  
16 incapacitated person, based on an examination on \_\_\_\_\_,  
17 2\_\_\_\_\_.

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19 1. A specific description of the physical, psychiatric  
or psychological diagnosis of the person.  
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2. A comprehensive assessment listing any functional impairment of the person and an explanation of how and to what extent these functional impairments may prevent that person from receiving or evaluating information in making decisions or in communicating informed decisions regarding himself/herself.

3. An analysis of the tasks of daily living the person is capable of performing without direction or with minimal direction.

4. A list of all medications the person is receiving, the dosage of the medications and a description of the effects each medication has on the person's behavior to the best of the declarant's knowledge.

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5. A prognosis for improvement in the person's condition and a recommendation of the most appropriate rehabilitation plan or care plan.

6. Other information the physician, psychologist or registered nurse deems appropriate.

7. What is the least restrictive living arrangement for the person examined?

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8. Is there any reason why this patient should not personally appear in Court?

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_