IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, PROBATE DIVISION

File No. _____

Estate of

_____

Alleged Person with a Disability

REPORT OF PHYSICIAN

_____, a licensed physician, submits the following Report on
[printed name of the physician]

_____, an alleged person with a disability (the "Respondent"), based
[printed name of the alleged person with a disability]

upon evaluations of the Respondent performed on _____.

NOTE: The evaluations upon which this Report is based must have been performed within three (3) months of the date the Petition for guardianship is filed.

1. The following is a description of the nature and type of the Respondent's disability and an assessment of how the disability impacts on the ability of the Respondent to make decisions or to function independently, including an underlying diagnosis and a description of the manifestations of the disability:

_____

_____

_____

_____

2. The following is an analysis and the results of evaluations of the Respondent's mental and physical condition, and (if appropriate) a description of the Respondent's educational condition, adaptive behavior and social skills:

_____

_____

_____

_____

3. The following is my opinion as to whether guardianship is needed, the type and scope of the guardianship needed, and the reasons for my opinion, including whether the Respondent is **totally** or only **partially** incapable of making **personal** and **financial** decisions and if only **partially**, the kinds of decisions which the Respondent can and cannot make:

_____

_____

_____

_____

4. The following is my recommendation as to the most suitable living arrangement for the Respondent and (if appropriate) the treatment or habilitation plan for the Respondent, and the reasons for my recommendation:

_____

_____

_____

_____

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If the description of the Respondent's mental, physical and educational condition, adaptive behavior or social skills is based upon evaluations by other professionals, all professionals preparing evaluations must also sign this Report.

5. The following are the names, addresses, certifications, licenses or other credentials, and signatures of each other person who performed an evaluation upon which this Report is based:

a. Name _____

Address _____

License (state and number)_____

Certification _____

Other credentials _____

Signature _____

b. Name _____

Address _____

License (state and number)_____

Certification _____

Other credentials _____

Signature _____

* _____

[signature of the physician preparing this Report]

_____

[license (state and number)]

_____

[address of the physician]

_____

[city/state/zip]

_____

[physician's telephone]

Certification _____

Other credentials _____

***This Report must be signed by a licensed physician.**