



**REPORT OF INTERDISCIPLINARY
EVALUATION TEAM**

Case No. _____
Court _____ District _____
County _____
Division _____

COMMONWEALTH OF KENTUCKY)
PETITIONER)
VS.)
_____)
RESPONDENT)

* * * * *

I, We, the undersigned, hereby report to the court as follows:

1. That the nature and extent of the Respondent's disabilities may be described as follows:

2. That the evaluations ordered regarding the Respondent are current and were performed and signed by the following individuals:

Evaluation: Name Title Date Performed _____

Intellectual: _____

Physical: _____

Educational: _____

Adaptive Behavior: _____

Social Skills: _____

3. That guardianship (management of "personal affairs" as defined in KRS 387.510):

Is needed for the following reason:

Is not needed for the following reason:

4. That the recommendation(s) of the type, scope, and duration of guardianship for the Respondent is/are as follows:

5. That conservatorship (management of financial resources):

Is needed for the following reason:

Is not needed for the following reason:

6. That the recommendation(s) of the type, scope, and duration of conservatorship for the Respondent is/are as follows:

7. That the social, educational, medical, and rehabilitative services currently being provided to the Respondent are as follows:

8. That appropriate alternatives to guardianship/conservatorship:

Are available (*explain*):

Are not available (*explain*):

9. That the recommendations and reasons as to the most appropriate treatment or rehabilitation plan and living arrangement for the Respondent are as follows:

10. That for the Respondent to attend the hearing on the Petition filed herein:

Would subject him/her to serious risk of harm for the following reason(s): _____

Would not subject him/her to serious risk of harm.

11. That appended hereto is a list of all medications currently being given to the Respondent on a continuous basis, the dosage of the medication, and a description of its impact upon the Respondent's mental and physical condition and behavior.

12. That any dissenting opinions or other comments are as follows:

Date

Signature of (*check one*):

- Licensed Physician
- Advanced Practice Registered Nurse
- Physician Assistant

Signature of Licensed/Certified Psychologist under
KRS Chapter 319

Signature of (*check one*):

- Licensed/Certified Social Worker
- Employee of the Cabinet for Health and Family Services who is qualified under KRS 335.080(1)(a), (b), and (c) and KRS 335.090(1)(a), (b), and (c)

Signature of Other

Name of Facility or Agency

Address

Telephone Number