



7. Please describe the nature and extent of the patient's abilities, including those that would allow him/her to accomplish certain tasks with reasonably available "supports and assistance"<sup>1</sup>:
8. Does the patient have the capacity to retain the following rights (If you cannot attest to yes or no, please explain what additional test/s can be done to achieve that information):
- a) Marry or divorce? Yes  No  Unknown
  - b) Reside in a place of his/her choosing, and consent or withhold consent to any residential or custodial placement? Yes  No  Unknown
  - c) Travel without the consent of a guardian? Yes  No  Unknown
  - d) Give, withhold, or withdraw consent and make other informed decisions relative to medical, mental, and physical examinations, care, treatment, and therapies? Yes  No  Unknown
  - e) Make end-of-life decisions including, but not limited to, a "do not resuscitate" order or the application of any medical procedures intended solely to sustain life, and consent or withhold consent to artificial nutrition and hydration? Yes  No  Unknown
  - f) Consent or refuse consent to hospitalization and discharge or transfer to a residential setting, group home, or other facility for additional care and treatment? Yes  No  Unknown
  - g) Authorize disclosures of confidential information? Yes  No  Unknown
  - h) Operate a vehicle\*? Yes  No  Unknown
  - i) Vote? Yes  No  Unknown
  - j) Be employed without the consent of a guardian? Yes  No  Unknown
  - k) Consent to or refuse educational services? Yes  No  Unknown
  - l) Participate in social, religious or political activities? Yes  No  Unknown
  - m) Buy, sell, or transfer real or personal property or transact business of any type? Yes  No  Unknown
  - n) Make, modify, or terminate contracts? Yes  No  Unknown
  - o) Bring or defend any action at law or equity? Yes  No  Unknown
  - p) Any other rights and powers? Please list.

COMPLETE EXPLANATION(S) FOR QUESTIONS a) through p) HERE.

If more space is required, use additional sheets and attach.

(\*If you answered "yes" to h), please state below whether a full driving evaluation has been conducted.)

<sup>1</sup> As defined in S.C. Code Ann. § 62-5-101(23), "Supports and assistance" includes:

(a) systems in place for the alleged incapacitated individual to make decisions in advance or to have another person to act on his behalf, including, but not limited to, having an agent under a durable power of attorney, a health care power of attorney, a trustee under a trust, a representative payee to manage social security funds, a Declaration of Desire for Natural Death (living will), a designated health care decision maker under Section 44-66-30, or an educational representative designated under Section 59-33-310 to Section 59-33-370; and

(b) reasonable accommodations that enable the alleged incapacitated individual to act as the principal decision maker, including, but not limited to, using technology and devices; receiving assistance with communication; having additional time and focused discussion to process information; providing tailored information oriented to the comprehension level of the alleged incapacitated individual; and accessing services from community organizations and governmental agencies.

9. Would the patient benefit from:

- a) Therapy or treatment? Yes  No
- b) Medical aids or equipment? Yes  No
- c) An operation or medical procedure(s)? Yes  No
- d) Psychiatric treatment? Yes  No

10. Has the patient had in the last six months:

- a) Hospitalization(s)? Yes  No
- b) Therapy or treatment? Yes  No
- c) Inpatient or outpatient surgery? Yes  No
- d) Major medical test(s)? Yes  No
- e) Psychological or psychiatric testing? Yes  No

11. In your opinion, does the patient have the ability to:

- a) effectively manage his/her property or individual financial affairs, provide for his/her support, or for the support of his/her legal dependents? Yes  No

If yes, is the ability limited in any way? Please explain:

- b) meet the essential requirements for his/her physical health, safety, or self-care. Yes  No

If yes, is the ability limited in any way? Please explain:

12. The patient continues to perform the following activities of daily living:

13. Does the patient have:

- a) A power of attorney? Yes  No  Unknown
- b) A healthcare power of attorney? Yes  No  Unknown
- c) A "living will"? Yes  No  Unknown

14. Does the patient have any of the following coverages?

- a) Health insurance? Yes  No  Unknown
- b) Medicare? Yes  No  Unknown
- c) Medicaid? Yes  No  Unknown
- d) Veteran's health care? Yes  No  Unknown

15. Does the patient have a primary caregiver?

Yes  No

If yes, provide caregiver's name, address, and relationship to the patient.

16. Please identify the persons with whom you met or consulted regarding the patient's mental or physical condition:

