

## Medical and Psychosocial Reassessment – Medical Report

Last name (at birth)		First name	
Date of birth	year-month-day	Sex	<input type="checkbox"/> F <input type="checkbox"/> M
Institution's file N°		Health insurance N°	
		Public Curator file N°	
		Current form of protective supervision	

## 1- Incapacity-Related Diagnosis

## Cognitive disorders

- ☐ Alzheimer's
- ☐ Dementia due to multiple etiologies (mixed)
- ☐ Infarct dementia
- ☐ Other \_\_\_\_\_

Since ? \_\_\_\_\_ (month) \_\_\_\_\_ (year)

## Mental illness

- ☐ Schizophrenia
- ☐ Bipolar disorder
- ☐ Other \_\_\_\_\_

Since ? \_\_\_\_\_ (month) \_\_\_\_\_ (year)

## Mental retardation

- ☐ mild
- ☐ moderate
- ☐ severe

## 2- Changes in State of Health

Since \_\_\_\_\_, have there been significant changes in this person's health ? ☐ Yes ☐ No  
(date of the last assessment)

If you answered no, go directly to point 4

## 3- Significant Details of the Person's Health and the Physical and Mental Examination


## 4- Incapacity

☐ The person is unable to :

	Degree			Length		
	no	partially	totally	permanently	temporarily	
Protect his/her person and exercise his/her civil rights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ specify : _____ years
Administer his/her property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ specify : _____ years

☐ The person is generally or usually able to take care of him/herself and administer his/her property, but for certain activities or temporarily, needs to be assisted or advised in the administration of his/her property.

☐ The person is able to take care of him/herself and administer his/her property.

## 5- Diagnosis Unrelated to Incapacity (cancer, cataracts, blindness, diabetes, hemiplegia, heart failure, respiratory failure, osteoarthritis, heart disease, arteriosclerosis, severe chronic obstructive lung disease, quadriplegia, deafness, etc.)


## 6- Identification of the Physician who Completed the Assessment

Last name (print)		first name (print)		Licence N°
Telephone	Extension	Fax	E-mail	
Signature				Date (year-month-day)