

THE GUARDIANSHIP BOARD

MALTA

Address all correspondence to:

The Registrar
1, Triq Patri Gwann Azzopardi,
Santa Venera, SVR 1614
Malta

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Medical Report

This Report should be drawn by a medical expert in the appropriate speciality (Psychiatry, Geriatrics, or Neurology), otherwise provide a detailed explanation of the reasons in Section 2 why you are completing this report.

Please read carefully before completing this report:

Before making a Guardianship order in respect of the proposed represented person, the

Guardianship Board must be satisfied that:

1. The person has a disability (intellectual impairment, mental disorder, brain injury, physical disability or dementia);
2. The disability makes the person incapable of making reasonable decisions about their person or circumstances (including accommodation and health care) or their financial and legal affairs.
3. There is a need for a Guardian. This will not be established if there are less restrictive means of meeting the person's needs.

The completeness and accuracy of the information that you provide will greatly assist the Guardianship Board to determine whether to make an order concerning the proposed represented person. The medical report needs to be completed up till thirty (30) days before the submission of the application.

1. Details of the Person who will be subject to Guardianship

Surname: _____

Name : _____

Date of Birth: ___/___/____ Gender: Male Female

ID Number _____

How long have you known this person _____

How many times have you seen this person over the past 12 months

2. Details of the Medical Practitioner

Surname: _____

Name: _____

Address: _____

Telephone: _____ Mobile: _____

Medical Council Registration Number _____

What is your relationship to the person _____

Specialisation _____

If you are not on the specialist register for Psychiatry, Geriatrics or Neurology please provide an explanation to why you that you are the appropriate professional to fill in this form

3. Diagnosis and assessment

Dementia Intellectual Disability Mental Health Condition

Brain Damage from Trauma Other

Specific Diagnosis _____

Approximately how long has the person had the mental incapacity? _____

- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____

Has this person ever expressed to you any views that may be relevant to the application

Do you recommend any further assessments for this person?

Yes No

Please Specify: _____

What are the social abilities of the person?

Please tick as appropriate and provide your observations and comments

	Comments
Listening Skills Does not follow what others are saying <input type="checkbox"/> Listens attentively to what others are saying <input type="checkbox"/>	
Communication Skills Communicates verbally and appropriately <input type="checkbox"/> Communicates non-verbally <input type="checkbox"/>	

<p>Anger Management Unable to control anger <input type="checkbox"/> Controls anger but cannot express it appropriately <input type="checkbox"/> Manages anger well <input type="checkbox"/></p>	
<p>Relationships Does not differentiate between relationships <input type="checkbox"/> Makes distinctions and behaves appropriately <input type="checkbox"/></p>	
<p>Compliance Complies with reasonable requests or suggestions and is able to resist unreasonable or unfair requests <input type="checkbox"/> Over compliance could present serious problems if exposed to people who would exploit this person <input type="checkbox"/> Under complaint- tends to resist reasonable requests <input type="checkbox"/></p>	

What are the physical abilities of the person?

Please tick as appropriate and provide your observations and comments

	Comments
<p>Self Care Capable of taking care of one's personal needs (eating, drinking, hygiene, toileting) <input type="checkbox"/> Requires full support in self-care needs <input type="checkbox"/> Fully dependent in self-care needs <input type="checkbox"/> Capable of taking care of personal belongings <input type="checkbox"/> Cannot take care of personal belongings <input type="checkbox"/></p>	
<p>Movement No difficulty in walking <input type="checkbox"/> Slight difficulty in walking (balance, co-ordination) <input type="checkbox"/> Cannot manage stairs <input type="checkbox"/> Uses wheelchair <input type="checkbox"/> Is bedridden <input type="checkbox"/></p>	
<p>Diet Special diet not required <input type="checkbox"/> Requires special diet <input type="checkbox"/></p>	
<p>Communication for Self Care Communicates health problems and seeks assistance <input type="checkbox"/> Does not always communicate about personal illness and needs asking <input type="checkbox"/></p>	

Rarely communicates about personal illness, others usually have to spot signs or symptoms before appropriate action is taken <input type="checkbox"/>	
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What are the emotional abilities of the person?

Please tick as appropriate and provide your observations and comments

	Comments
<p>Withdrawal/Isolation</p> <p>Outgoing with most other people <input type="checkbox"/></p> <p>Generally isolated, withdrawn person with whom it is difficult to create a relationship <input type="checkbox"/></p> <p>A very isolated person, difficult to make contact with <input type="checkbox"/></p>	
<p>Aggression, excessive anger, bad temper</p> <p>Never displays aggression, excessive anger or bad temper, or does on occasion but never presents a problem <input type="checkbox"/></p> <p>Occasional display of aggression, excessive anger or bad temper, presents a small problem <input type="checkbox"/></p> <p>Aggression, excessive anger or bad temper is a serious problem <input type="checkbox"/></p>	
<p>Depression</p> <p>Does not get depressed, or is only occasional depressed <input type="checkbox"/></p> <p>Often depressed or has mood fluctuations <input type="checkbox"/></p> <p>Severe depressed <input type="checkbox"/></p> <p>Is not a problem <input type="checkbox"/></p> <p>Is a problem <input type="checkbox"/></p>	
<p>Diagnosis</p> <p>No diagnosed psychiatric disorder <input type="checkbox"/></p> <p>Diagnosed psychiatric disorder (please specify)</p>	

Can the person understand and make decisions about the following:

A simple decision would one requiring the adult to consider choices about day-to-day life, whereas a complex decision would require the adult to consider choices which may have long-term consequences

	Complex decisions	Simple decisions
Personal Health Care	Yes____ No____	Yes____ No____
Lifestyle/accommodation choices	Yes____ No____	Yes____ No____
Financial and legal affairs	Yes____ No____	Yes____ No____

Declaration

I hereby declare that to the best of my knowledge, all the information given in this medical report is correct

Signature

Date

Name and Surname

Rubber Stamp
