PC-2.4

Decision Making Assessment Tool
(referred to as DMAT)
formerly SW-78

R.I.G.L. 33-15-4

This form is a Statutory form.

This form must accompany **Form PC-2.3. Petition for a Limited Guardianship/Guardianship** for Adults. It will be used by the Probate Court to determine whether to appoint a Guardian to assist the individual in some or all areas of decisionmaking.

- A treating physician must complete the document. If the physician must consult other persons to complete the entire form, the names of those individuals must be listed on the Summary portion of the form.
- Additionally, professionals or other persons acquainted with the individual being assessed may also submit their own form.
- If there is information of which a non-physician does not have knowledge, those entries may be left blank or an investigation may be undertaken to complete the entire document.
- Names of any individual from whom information is derived should be listed on the Summary portion of the form.

The Petitioner or Attorney:

- Presents the form for filing.

The Probate Clerk:

- Determines that all entries are complete.

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DECISION-MAKING ASSESSMENT TOOL

Name of Individual being assessed: ______________________

Current Address: ______________________

____

Date of Birth: ______________________

Permanent Address (if different): ______________________

____

Instructions for Completion

This document will be used by a Probate Court to determine whether to appoint a guardian to assist this individual in some or all areas of decision-making.

This document has two parts. Please first complete the part which is right after these instructions, titled Assessment. Then complete the second section, titled Summary.

To a physician completing this document: The individual's treating physician must complete this document. If there is any information of which the treating physician does not have direct knowledge, he or she is encouraged to make such inquiries of such other persons as are necessary to complete the entire form. Those persons might include other medical personnel such as nurses, or other persons such as family members or social service professionals who are acquainted with the individual. If the physician has received information from others in completing the form, the names of those individuals must be list on Summary.

To a non-physician completing this document: Professionals or other persons acquainted with the individual being assessed may also complete this document. If there is information of which a non-physician does not have knowledge, such non-physician may either leave portions of the document blank, or also make inquiries or do such investigation as is necessary to complete the entire document. Again, the names of any individual from whom information is derived should be listed on the Summary.

The document must be signed and dated by the person completing it. It does not need to be notarized.

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A. BIOLOGICAL ASSESSMENT

THE FOLLOWING IS BASED UPON A PHYSICAL EXAMINATION CONDUCTED

BY ME ON ______________________ (DATE)

1. DIAGNOSIS and PROGNOSIS:

2. MEDICATIONS (PLEASE LIST):

How do the above medications, if any, affect the individual's decision-making ability?

Please explain:

3. CURRENT NUTRITIONAL STATUS:

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B. PSYCHOLOGICAL ASSESSMENT

1. **MEMORY**
   (CIRCLE ONE)
   (A) Intact
   (B) Mild Impairment
   (C) Moderate Impairment
   (D) Severe Impairment

2. **ATTENTION**
   (CIRCLE ONE)
   (A) Intact
   (B) Mild Impairment
   (C) Shifting/Wandering
   (D) Delirium
   (E) Unresponsive

3. **JUDGEMENT**
   (CIRCLE ONE)
   (A) Intact
   (B) Able to Make Most Decisions
   (C) Impaired
   (D) Gross Impairment

4. **LANGUAGE**
   (CIRCLE ONE)
   (A) Intact
   (B) Sensory Deficits:
   Hearing/Speech/Sight
   (C) Impairment In Comprehension/Speech
   Mild/Moderate/Severe
   (D) Completely Unresponsive

5. **EMOTION (CIRCLE ALL THAT APPLY)**

   (A) ANXIETY/DEPRESSION
   (1) None
   (2) History of Anxiety/Depression
   (3) Moderate Symptoms of Anxiety/Depression
   (4) Severe symptoms with sleep/appetite/energy disturbance
   (5) Suicide/Homicidal

   (B) OTHER
   (1) Suspiciousness/Belligerence/Explosiveness
   (2) Delusions/Hallucinations
   (3) Unresponsive

If you circled any of the above, other than (A) or (1) for any of the above categories, please explain whether the situation is treatable or reversible, and if so, how:

C. SOCIAL ASSESSMENT

1. MOBILITY (CIRCLE ALL THAT APPLY)

(A) Intact/Exercises

(B) Drives Car or Uses Public Transportation

(C) Independent Ambulation in Home Only

(D) Walker/Cane

(E) Requires Assistance

If you circled (C), (D) or (E), is situation treatable or reversible? If so, how?

2. SELF CARE (CIRCLE ALL THAT APPLY)

(A) No Assistance Needed

(B) Requires Assistance with:

- (1) Meals
- (2) Bathing
- (3) Dressing
- (4) Toileting/Feeding

If you circled any of (B), is individual aware that assistance is required?

Is individual willing to accept assistance?

Is individual able to arrange for assistance?

3. CARE PLAN MAINTENANCE (CIRCLE ALL THAT APPLY)

(A) No Active Problem

(B) Initiates Problem Identification

(C) Actively Cooperative

(D) Passively Cooperative

(E) Passively Uncooperative

(F) Actively Uncooperative

4. SOCIAL NETWORK RELATIONSHIPS (CIRCLE ONE IN (A) AND ONE IN (B))

(A) SUPPORT:

(1) Very Good Supportive Network

(2) Some Support From Family and Friends

(3) No Or Limited Support From Family/Friends

(4) Needs Community Support

(5) Isolated/Homebound

(B) SOCIAL SKILLS

(1) Very Good Social Skills

(2) Good Social Skills

(3) Interacts With Prompting

(4) Isolated

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D. SUMMARY

I hereby certify that I have reviewed sections A,B, & C attached hereto and based on such assessments that the individual's decision-making ability is as follows:

(1) PLEASE DESCRIBE AS FULLY AS YOU CAN THE INDIVIDUAL'S DECISION-MAKING ABILITY IN EACH OF THE FOLLOWING AREAS:

(A.) FINANCIAL MATTERS

(B) HEALTH CARE MATTERS

(C) RELATIONSHIPS

(D) RESIDENTIAL MATTERS

(2) PLEASE INDICATE YOUR OPINION REGARDING WHETHER THE INDIVIDUAL NEEDS A SUBSTITUTE DECISION-MAKER IN ANY OF THE FOLLOWINGS AREAS: (Circle one for each category. If you circle "limited" for any category, please explain.)

(A) FINANCIAL MATTERS	Yes	No	Limited
(B) HEALTH CARE MATTERS	Yes	No	Limited
(C) RELATIONSHIPS	Yes	No	Limited
(D) RESIDENTIAL MATTERS	Yes	No	Limited

(E) OTHER: If there are any other areas in which you think the individual lacks decision-making ability or has limited decision-making ability please explain.

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____

Signature

____

Name (Print or Type)

____

Title

Date:

Names and titles of others who assisted in Preparation of This Assesment: