MEDICAL AFFIDAVIT

Please complete this form to the best of your knowledge and ability.

Today's Date: 1/27/2023	Referring Court: Lafayette

EXAMINER INFORMATION

Examiner's Last Name: Perkins First: Frank	Middle: N	Specialty: Psychiatry	
Hospital / Medical Group Affiliation: Precise Forensic Services, PLLC	Years Practicing: 7	State of Licensure: MS	
Address: 3531 Lakeland Drive, Suite 1060 Flowood, MS 39232	Designation: M.D. ☑ D.O. ☐ N.P. ☐ P.A. ☐ Ph.D. ☐		

§§ 93-20-305 & 407

Professional evaluation

The chancery court must conduct a hearing to determine whether a guardian/conservator is needed for the respondent. Before the hearing, the court, in its discretion, may appoint a guardian ad litem to look after the interest of the person in question; the guardian ad litem must be present at the hearing and present the interests of the respondent.

The chancery judge shall be the judge of the number and character of the witnesses and proof to be presented, except that the proof must include certificates made after a personal examination of the respondent by the following professionals, each of whom shall make in writing a certificate of the results of that examination to be filed with the clerk of the court and become a part of the record of the case, two (2) licensed physicians; or one (1) licensed physician and either one (1) licensed psychologist, nurse practitioner, or physician's assistant.

The personal examination may occur face-to-face or via telemedicine, but any telemedicine examination must be made using an audio-visual connection by a physician licensed in this state and as defined in Section 83-9-351. A nurse practitioner or physician assistant conducting an examination shall not also be in a collaborative or supervisory relationship, as the law may otherwise require, with the physician conducting the examination. A professional conducting an examination under this section may also be called to testify at the hearing.

§ 93-20-301

Basis for appointment of guardian

The court may appoint a guardian for an adult when the respondent lacks the ability to meet essential requirements for physical health, safety or self-care because the adult is unable to receive and evaluate information or make or communicate decisions, even with appropriate supportive services or technological assistance; or the adult is found to be a person with mental illness or a person with an intellectual disability as defined in Section 41-21-61 who is also incapable of taking care of his or her person.

§ 93-20-401

Basis for appointment of conservator

The court may appoint a conservator for the property or financial affairs of an adult if the court finds by clear and convincing evidence that the adult is unable to manage property or financial affairs because of a limitation in the adult's ability to receive and evaluate information or make or communicate decisions, even with the use of appropriate supportive services or technological assistance; the adult is missing, detained, incarcerated, or unable to return to the United States.

Signature [signature] MD

Date 1/27/2023

PATIENT INFORMATION

Patient's Last Name: Sullivant First: Robert		M: Burnell		Marital Status: Divorced	
Is this the patient's legal name? ☑ Yes ☐ No	If not, what is his / her legal name?	Former name:	Birth date: 11/19/1933	Age: 89	Sex: ☑ M ☐ F
Address: 100 Azaela Drive Apt 153 Oxford, MS 38655					

Have you treated this patient in the past for his / her medical needs, whether related or unrelated to this exam?	☐ Yes ☑ No	If yes, indicate the dates and circumstances within the last year, and / or reference if you have been the patient's personal physician for a period of time and the time frame:		
Did a friend or family member accompany the patient during your examination?	☐ Yes ☑ No	Name / Relationship to Patient: Phone Number:	Is this the patient's primary caretaker?	☐ Yes ☐ No

If the above named individual is not the patient's primary caretaker, who is? (Name / Phone / Relationship to Patient):

EVALUATION

MEDICAL HISTORY – **Physical**

Has the patient experienced	Physical Impairments or Chronic Pain:	☑ YES ☐ NO ☐ UNKNOWN
	Chronic Diseases or Illnesses:	☑ YES ☐ NO ☐ UNKNOWN
	Surgery within the past year	☐ YES ☑ NO ☐ UNKNOWN
Are there any physical limitations affecting the patient's	Activities of Daily Living	☑ YES ☐ NO ☐ UNKNOWN
	Cognitive / Memory Abilities	☑ YES ☐ NO ☐ UNKNOWN
In the last six months, has the patient had:	Hospitalizations	☐ YES ☑ NO ☐ UNKNOWN
	Therapy or Treatment	☐ YES ☑ NO ☐ UNKNOWN
	Psychological or Psychiatric Testing	☐ YES ☑ NO ☐ UNKNOWN

Patient's Current Condition / Status of Physical Illnesses:

Mr. Sullivant appears to have stable impairments in mobility requiring a walker and chronic medical condition of hypertension which he takes medications for.

History of Substance Abuse / Use ☑ Denies Substance Use ☐ Prescribed Medications Only

Drug(s) of Choice and Age of Onset:

Has the Patient Previously Sought Addiction Treatment? ☐ Yes ☐ No

Patterns of Substance Use / Abuse

How Much: How Often:

Methods of Use: ☐ Oral ☐ Snort ☐ Inject ☐ Insert ☐ Inhale

☐ Other: ______

MEDICAL HISTORY – **Mental**

Previous Psychiatric Issues:

Patient denies any past psychiatric issues.

Do these psychiatric / mental illnesses affect the patient's ability to take care of him / herself? ☑ Yes ☐ No

Does the patient suffer from a developmental and / or intellectual disability? ☐ Yes ☑ No

Previous In-Patient or Out-Patient Psychiatric Treatment (with dates and location):

Patient denies and past inpatient or outpatient psychiatric treatment.

Does the Patient Indicate Homicidal Ideation or Behavior? ☐ Yes ☑ No

Does the Patient Indicate Suicidal Ideation or Behavior? ☐ Yes ☑ No

Describe Other Counseling and / or Therapeutic Experiences:

None known

Set forth the results of any tests which bear on the issue of incapacity and date of test (attach results if necessary):

MOCA (1/17/2023) - 20/30, Clock Drawing Impaired, Trail A 73 seconds, Trail B 300 sec (did not complete)

Traumatic Event Exposure / History
(Where applicable, identify type and date of event):

- ☐ Serious Accidents: ______
- ☐ Natural Disaster: ______
- ☐ Witness to Traumatic Event: ______
- ☐ Sexual Assault: ______
- ☐ Physical Assault: ______
- ☐ Childhood Molestation: ______
- ☐ Close Family / Friend Murdered: ______
- ☐ Homelessness: ______
- ☐ Victim of Stalking / Bullying: ______
- ☑ N / A
- ☐ Other (Specify): ______

Social / Cultural History
(Note / Describe Relationships as Appropriate):

Parents:	☐ Close ☐ Amicable ☐ Estranged ☑ Other: Deceased
Spouse / Partner:	☐ Close ☐ Amicable ☐ Estranged ☑ Other: Deceased
Children:	☐ Close ☐ Amicable ☑ Estranged ☐ Other:
Siblings:	☐ Close ☐ Amicable ☐ Estranged ☑ Other: N/A
Other Family:	☑ Close ☐ Amicable ☐ Estranged ☐ Other:
Friends / Colleagues:	☑ Close ☐ Amicable ☐ Estranged ☐ Other:

Indication of Functional Limitations (Check Major Life Areas Affected)	☐ Basic Living Skills (eating, bathing, dressing, etc.) ☑ Instrumental Living Skills (maintaining a home, managing money, local travel, taking medications, etc.) ☑ Social Functioning (ability to function within the family, vocational or educational settings, other social contexts)
Does the patient have the mental or physical capacity to effectively manage his / her property?	☐ Yes ☑ No ☐ Undetermined
Does the patient have the mental or physical capacity to make necessary daily living and health care decisions?	☐ Yes ☑ No ☐ Undetermined

Initial Behavioral Observations	Speech	☑ Appropriate ☐ Slowed ☐ Mechanical ☐ Rapid ☐ Other:
	Behavior	☑ Appropriate ☐ Withdrawn ☐ Bizarre ☐ Volatile ☐ Other:
	Appearance	☑ Appropriate ☐ Disheveled ☐ Unclean ☐ Inappropriately Dressed ☐ Other:
	Mood	☑ Appropriate ☐ Manic ☐ Depressed ☐ Labile ☐ Irritable ☐ Other:
	Affect	☑ Appropriate ☐ Flat ☐ Labile ☐ Other:
	Oriented To	☑ Place ☑ Time ☑ Person ☑ Situation ☐ Other:
	Thought Content	☑ Appropriate ☐ Incoherent ☐ Obsessive ☐ Other:
	Memory	☐ Appropriate ☐ Repressed ☑ Confused ☑ Other: Impaired in Short Term and Long Term
	Judgment / Insight	☐ Appropriate ☑ Impaired ☐ Suicidal ☐ Homicidal ☐ Other:

Comments on Mental / Physical Health: Mr. Sullivant's presentation is most consistent with a Major Vascular Neurocognitive Disorder without Behavioral Disturbance. This is evidenced by impairments in memory, language, and visiospatial/executive function as demonstrated in testing and clinical impression during his interview. He has an awareness and ability to voice his wishes and needs but due to his impaired cognitive function does not have the capacity to consistently execute those wishes and needs. There are lucid intervals in his illness that enable him to inform those assisting with his affairs of his wishes, but due to the nature of his illness he cannot consistently provide that direction nor appropriately engage or execute contracts. He will be best served by a neutral, independent conservator to manage his finances with his direction and a family member or concerned party who he is agreeable with helping to manage his person.

SUMMARY / RECOMMENDATION

This Evaluation was Conducted (Check all that Apply):	☑ In Person ☐ Via Audiovisual Telemedicine ☐ At Hospital / Medical Office ☐ At the Patient's Residence ☐ Other:	
	If via Telemedicine, who assisted you with the evaluation? (Name, Designation)	Your Mississippi License Number: 25109

Diagnosis	Did you perform a physical exam on the patient? ☐ Yes ☑ No	Did any concerns result from the physical exam? ☐ Yes: ☐ No ☐ N/A	
	Based on the foregoing evaluation:	☑ I DO ☐ I DO NOT	believe this patient is a person incapable of managing his / her own person under § 93-20-301 or financial affairs under §93-20-401, and is in need of a Guardian and / or Conservator (check all that apply): ☐ Guardian (Person) ☐ Conservator (Financial Affairs) ☑ Both
		I find that the patient is in need of treatment ☐ Temporarily ☑ Permanently ☐ Other:	
	I recommend the Court require re-evaluation in:	☐ 60 days ☐ 6 months ☐ 1 year ☑ N/A ☐ Other:	

Summary of Diagnosis: Major Vascular Neurocognitive Disorder without Behavioral Disturbance

I, Frank Perkins, MD, the above named examiner, certify that this patient's **examination** was completed on (date) 01/17/2023 at (time) 1400, and that this **evaluation** and **recommendation** was completed on (date) 01/27/2023 at (time) 1500.

I hereby certify that that the facts stated above, and the information contained in this report, are true to the best of my knowledge and belief.

	Signature	
	Printed Name	Frank Perkins MD
	Date	1/27/2023