



PHYSICIAN'S REPORT

State Form 45670 (R3 / 9-06) / OGC 0013

STATE OF INDIANA)
)
COUNTY OF _____)
)
IN THE MATTER OF)
)
THE HEALTH CARE REPRESENTATIVE FOR)
)
_____, ADULT)

SS: _____

IN THE _____ COURT

CAUSE NUMBER: _____

_____, a physician licensed to practice medicine in the State of Indiana, submits the following report regarding _____, based on an examination on _____, 20_____.
name of incapacitated person

1. Describe the nature and type of _____'s incapacity.
name of incapacitated person

2. State whether, in your opinion, _____ is totally or only partially incapable of making
name of incapacitated person
personal health care decisions; and, if partially capable, the kinds of decisions which he/she can and cannot make. Include the reason for this opinion.

3. State whether, in your opinion, health care decisions will be required to be made for _____;
name of incapacitated person
and, if applicable, describe the possible kinds of health care decisions. Include the reasons for your opinion.

Signature of physician	Date (month, day, year)
Address (number and street, city, state, and ZIP code)	Telephone number ()