(Copy Receipt) (Clerk's Date Stamp)

SUPERIOR COURT OF WASHINGTON COUNTY OF SPOKANE

In the Guardianship of:	CASE NO. 21-4-01873-32
KENNETH W. REESE	MEDICAL/PSYCHOLOGICAL REPORT
Respondent	(MDR)

This form is required by Washington state law for all Guardianships. *See RCW 11.88.045.* Your assistance in completing this form on or before _____ is appreciated. (Please type or print clearly.) If there are concerns about patient/doctor privilege please see exception to this privilege in RCW 11.88.045, .090, and *In re Atkins*, 57 Wn. App. 771, 775, 790 P.2d 210 (1990).

I have been chosen in the above matter to examine and interview the above named individual, and I submit the following report:

A. My name, title, medical or psychological specialty, address, telephone number are as follows (See RCW 11.88.045(4)(a)):

B. My education and experiences that are pertinent to the type of disorder or incapacity involved in this case are as follows: (See RCW 11.88.045(4)(b); *a resume*/*curriculum vitae may be attached.*):

C. Date of most recent examination of the Respondent (most recent exam must be within 30 days of date of this request per RCW 11.88.045(4)(c)):

D. A summary of the relevant medical, functional, neurological, or mental health history of the Respondent as known to me is as follows (See RCW 11.88.045(4)(d):

E. My findings as to the Respondent as it relates to the CONDITION OF the Respondent. (See RCW 11.88.045(4)(e))

F. The following medication(s) are currently prescribed to the Respondent for the following condition(s) (See RCW 11.88.045(4)(f)).

Medication	**Condition (Identify diagnosis)**	**Dosage**

Other:

G. Per RCW 11.88.045(4)(g), the effect of these current medications on the Respondent's ability to understand or participate in the Guardianship proceedings is:

H. Per RCW 11.88.045(4)(h), my opinion as to the specific assistance the Respondent needs is (*including items such as household chores, managing finances*):

I. I have also met or spoken with the following individuals regarding the Respondent (See RCW 11.88.045(4)(i)):

OTHER QUESTIONS RELATED TO THIS MATTER (**OPTIONAL**):

J. I have treated the Respondent since?

K. The symptoms manifested by the Respondent are described below and they first appeared: _____. (Please describe if there was a single precipitating event or have the symptoms progressively worsened.)

L. The symptoms present on a regular and consistent basis or are they sporadic or episodic?

M. In my opinion, the extent of symptoms of cognitive OR physical decline may be caused by reversible factors, such as medication, inadequate nutrition or hydration, mental illness, socioeconomic factors, neglect or abuse, etc.? (please describe or explain)

N. What is the prognosis of the Respondent?

O. Is the disability or disorder likely to improve over time or become progressively worse?

P. My findings with respect to the projected long-term impact on the Respondent's MENTAL OR PHYSICAL functional capacity?

I certify (or declare) under penalty of perjury under the laws of the State of Washington that to the best of my knowledge the statements above are true and correct.

SIGNED AT SPOKANE, WASHINGTON THIS _____ DAY OF _____, 2021.

Signature of Physician/Psychologist/ Advanced Registered Nurse Practitioner	Printed Name of Physician/Psychologist/ Advanced Registered Nurse Practitioner
Address	City, State, Zip Code
Telephone/Fax Number	Email Address