ATTORNEY OR PARTY WITHOUT ATTORNEY (NAME, STATE BAR NUMBER AND ADDRESS)		FOR COURT USE ONLY
TELEPHONE NUMBER:	FAX NO. (Optional):	
EMAIL ADDRESS (Optional):		
ATTORNEY FOR (Name):		
SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN LUIS OBISPO STREET ADDRESS: 1035 Palm Street, Room 385 MAILING ADDRESS: Same as above CITY AND ZIP CODE: San Luis Obispo, CA 93408 BRANCH NAME: San Luis Obispo Division		
LPS CONSERVATORSHIP OF:		CASE NUMBER:

CONFIDENTIAL MEDICAL INFORMATION IN SUPPORT OF REAPPOINTMENT OF LPS CONSERVATOR

DECLARATION OF PHYSICIANS OR QUALIFIED LICENSED PSYCHOLOGISTS FOR REAPPOINTMENT OF LPS CONSERVATORSHIP

LPS CONSERVATORSHIP OF:	CASE NUMBER

DECLARATION OF PHYSICIAN OR QUALIFIED LICENSED PSYCHOLOGIST FOR REAPPOINTMENT OF LPS CONSERVATORSHIP
(Welfare & Institutions Code §5361)

☐ The renewal of the conservatorship of ___________________________________for an additional one year period IS NOT recommended because this person is no longer gravely disabled as defined under §5008(h)(1)(a) of the Welfare & Institutions Code.

☐ The renewal of the conservatorship of ____________________________________for an additional one year period IS recommended because this person is still gravely disabled as defined under §5008(h)(1)(a) of the Welfare & Institutions Code.

Date of current evaluation: _____________________________.

1. Is there a current mental disorder? _____________________________________.
2. Current Diagnosis:____.
3. Current Mediations:____
____.
4. Please explain the symptoms.____
____
____.
5. Can the individual provide for his or her basic needs (i.e., food, clothing, or shelter) in an unsupervised setting? Why do you feel he or she can or cannot? ____
____
____.

6. Conservatee's Current Placement Level of Care ___________________________.

The least restrictive level of care in which this person can be treated is:
☐ Locked IMD ☐ Skilled Nursing Facility ☐ Licensed Board and Care
☐ Other ______________________.

☐ This person lacks capacity to give informed consent, or is unable or unwilling to voluntarily consent to treatment specifically related to his/her being gravely disabled as follows: *(Note, if this box is checked, please also check box #1 under Imposition of Disabilities below).* ____
____.

☐ This person lacks capacity to give informed consent for routine medical treatment unrelated to remedying or preventing the recurrence of his/her being disabled as follows: *(Note, if this box is checked, please also check box #2 under Imposition of Disabilities below).* ____
____.

LPS CONSERVATORSHIP OF:	CASE NUMBER

Imposition of Disabilities: I make the following recommendations regarding the imposition of disabilities on the above named person:

☐ 1. Conservatee should not have the right to consent to treatment related specifically the Conservatee's being gravely disabled.

☐ 2. Conservatee should not have the right to consent to routine medical treatment unrelated to remedying or preventing the recurrence of the Conservatee's grave disability.

☐ 3. Conservatee should not possess a license to operate a motor vehicle.

☐ 4. Conservatee should not be allowed to enter into contracts in excess of $15.00.

☐ 5. Conservatee should not have the right to possess, have custody of, or control a firearm or any other deadly weapon because it would present a danger to the safety of the person or to others.

☐ 6. Conservatee should not have the right to vote because the Conservatee is not capable of completing an affidavit of voter registration.

I declare that I am a ☐ physician, licensed in the State of California, OR ☐ a psychologist licensed in the State of California, who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional mental disorders.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on *(date):* _________________

______________________________ ______________________________

Printed Name Signature (blue ink)

I declare that I am a ☐ physician, licensed in the State of California, OR ☐ a psychologist licensed in the State of California, who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional mental disorders.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on *(date):* _________________

______________________________ ______________________________

Printed Name Signature (blue ink)