



# health care professional review GUARDIANSHIP AND ADMINISTRATION BOARD

Application No. \_\_\_\_\_

## health care professional providing this report

please stamp or fill in details below

Your Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_

Preferred Contact Telephone Numbers  
\_\_\_\_\_

Fax Number \_\_\_\_\_

Email address \_\_\_\_\_

In what capacity do you know the person? (Please tick)

GP     Psychologist

Specialist: type \_\_\_\_\_  
(eg. Psychiatrist)

## the person

Details of the person for whom an application for guardianship and/or administration is being made to the Board.

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

How long have you known the person? \_\_\_\_\_

On what date did you last personally examine the person?  
\_\_\_\_\_

Are you the person's regular medical attendant? please tick  Yes  No

Where consent for medical treatment is required for the person, from whom do you obtain that consent? Refer to Fact Sheet 6.  
\_\_\_\_\_

## review

I completed/have reviewed the previous HCPR dated \_\_\_\_\_

by [myself] [other practitioner \_\_\_\_\_] (name)

I disagree with the contents of that report in the following respects:

- Disability
- Incapacity to make reasonable judgments
- Need for a guardian or administrator

I agree with the contents of that report in the following respects:

- Disability
- Incapacity to make reasonable judgments
- Need for a guardian or administrator

Have you discussed the diagnosis with the proposed represented person?

Yes     No

I presently have the following concerns with regard to this person (any other comments)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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## applicant's details

Please give details of the person who is making the application to the Board and/or requested this Health Care Professional Report from you.

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_

Preferred Contact Telephone Numbers

\_\_\_\_\_

Fax Number \_\_\_\_\_

Email address \_\_\_\_\_

## person's attendance at hearing

Does the person have any physical disability that would prevent him or her from attending a Guardianship and Administration Board hearing?  
(Please tick)

Yes  No

If Yes, please explain the condition:

\_\_\_\_\_  
\_\_\_\_\_

Does the person's mental condition prevent him or her from attending a hearing? (Please tick)

Yes  No

If Yes, please explain the condition:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## confidentiality

The information in this report may be provided without the consent of the person about whom it is written. However, the Board may provide a copy of this report to the person about whom it is written or an 'interested party' to the proceedings. If you have any concerns about disclosure of information from the report, please indicate below.

Do you have concerns about disclosing the contents of this report to the person about whom it is written or any 'interested party'? (Please tick)

Yes  No

If Yes, please provide details:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have provided this report in good faith and have reasonable and probable grounds for believing the report to be true.

Signed \_\_\_\_\_

Dated \_\_\_\_\_

**Thank you for your time in completing this report.**

**Your assistance is greatly appreciated.**

### *Office Use Only*

Date report received:

Date data entered:

Attach to Application No.