



**REPORT OF INTERDISCIPLINARY  
EVALUATION TEAM**

Case No. \_\_\_\_\_  
Court \_\_\_\_\_  
County \_\_\_\_\_

COMMONWEALTH OF KENTUCKY )  
Petitioner )  
VS. )  
\_\_\_\_\_ )  
Respondent )

\* \* \* \* \*

We, the undersigned, hereby report to the court as follows:

1. That the nature and extent of the Respondent's disabilities may be described as follows:

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

2. That the evaluations ordered regarding the Respondent are current and were performed and signed by the following individuals:

Evaluation:	Name	Title	Date Performed
Intellectual:	_____	_____	_____
Physical:	_____	_____	_____
Educational:	_____	_____	_____
Adaptive Behavior:	_____	_____	_____
Social Skills:	_____	_____	_____

3. That guardianship:

Is needed for the following reason:

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Is not needed for the following reason:

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4. That the recommendation(s) of the type, scope, and duration of guardianship for the Respondent is/are as follows:

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5. The conservatorship:

Is needed for the following reason:

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Is not needed for the following reason:

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6. That the recommendation(s) of the type, scope, and duration of conservatorship for the Respondent is/are as follows:

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7. That the social, educational, medical, and rehabilitative services currently being provided to the Respondent are as follows:

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8. That appropriate alternatives to guardianship/conservatorship:

Are available (explain):

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Are not available (explain):

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9. That the recommendations and reasons as to the most appropriate treatment or rehabilitation plan and living arrangement for the Respondent are as follows:

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10. That for the Respondent to attend the hearing on the Petition filed herein:

- Would subject him/her to serious risk of harm.
- Would not subject him/her to serious risk of harm.

11. That appended hereto is a list of all medications currently being given to the Respondent on a continuous basis, the dosage of the medication, and a description of its impact upon the Respondent's mental and physical condition and behavior.

12. That any dissenting opinions or other comments are as follows:

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Date

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Signature of Licensed Physician

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Signature of Licensed/Certified Psychologist

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Signature of Licensed/Certified Social Worker

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Signature of Other

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Name of Facility or Agency

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Address

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Telephone Number