



# Health Professional Report Form

## GUARDIANSHIP DIVISION

For more information about completing the Health Professional Report Form please contact NCAT's Guardianship Division on (02) 9556 7600 or 1300 006 228.

### 1. Information about the subject person

title  Mr  Mrs  Miss  Ms  Other (specify) \_\_\_\_\_

given names \_\_\_\_\_

family name \_\_\_\_\_

date of birth \_\_\_\_\_

### 2. Information about you

title  Mr  Mrs  Miss  Ms  Dr  Prof  Other (specify) \_\_\_\_\_

given names \_\_\_\_\_

family name \_\_\_\_\_

professional qualifications  
(please outline) \_\_\_\_\_

### You organisation name and contact details

organisation name \_\_\_\_\_

street/PO Box \_\_\_\_\_

suburb/town, state, postcode \_\_\_\_\_

phone \_\_\_\_\_

fax \_\_\_\_\_

mobile phone \_\_\_\_\_

pager \_\_\_\_\_

email \_\_\_\_\_

### What is your professional relationship to the subject person?

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

How often do you see the person? \_\_\_\_\_

When did you last see the person? \_\_\_\_\_

### 3. Medical information about the subject person

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Does the person have a disability?  Yes  No

Please indicate:

**Dementia**

Is this disability/condition  Mild?  Moderate?  Severe?

Is this disability/condition  Static?  Progressing slowly?  Progressing rapidly?  Improving?

**Please state specific diagnosis if known** (e.g. Vascular Dementia, Alzheimer's Disease, Korsakoff's syndrome, AIDS related dementia, Pick's Disease, Lewy body dementia):

How long has the person had this disability/condition?

Other relevant information

**Intellectual Disability**

Is this disability/condition  Mild?  Moderate?  Severe?

Is this disability/condition  Static?  Fluctuating?  Improving?  Other?

**Please state specific diagnosis if known** (e.g. Down Syndrome, Autism, Prader Willi Syndrome):

How long has the person had this disability/condition?

Other relevant information

**Brain Injury**

Is this disability/condition  Mild?  Moderate?  Severe?

Is this disability/condition  Static?  Fluctuating?  Improving?  Deteriorating?

**Please state specific diagnosis if known** (e.g. CVA, traumatic brain injury, hypoxic brain injury):

How long has the person had this disability/condition?

Other relevant information

**Mental Illness**

Is this disability/condition  Mild?  Moderate?  Severe?

Is this disability/condition  Static?  Fluctuating?  Improving?  Deteriorating?

**Please state specific diagnosis if known** (e.g. Schizophrenia, Bi-polar Disorder, Depression):

How long has the person had this disability/condition?

Other relevant information

**Other disability / medical condition that affects the person's decision making capacity** (please specify)

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Is this disability/condition  Mild?  Moderate?  Severe?

Is this disability/condition  Static?  Fluctuating?  Improving?  Deteriorating?

How long has the person had this disability/condition?

Other relevant information

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**Please state any other medical conditions that the person has and any current medication or other treatment**

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**Is any of the person's medication likely to affect his or her decision making capacity?**

No  Yes, provide details.

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**Does the person's disability affect their capacity to make informed decisions about the following?**

**Accommodation, care and services?**  Yes  No

If yes, in what ways?

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**Health and medical care?**  Yes  No

If yes, in what ways?

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**Financial affairs?**  Yes  No

If yes, in what ways?

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**Other?**  Yes  No

If yes, please provide details:

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**Has the person's cognitive ability been assessed?**

Yes  No

*If Yes, please provide the nature and date of the assessment/s and the result/s*

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***(Please provide copies of the above reports/assessments)***

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**Is the person subject to any orders in other relevant jurisdictions?**

Yes  No,  Don't know,

*If Yes, please provide details including the date on which the order lapses.*

e.g. Protected Estates Order, Community Treatment Order, Family Court, Criminal Matter

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## **Involving the person**

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**Please indicate which of the following applies:**

The person:

- speaks English
  - speaks another language (please specify)
  - uses sign language / Makaton / language board (please specify)
  - uses gestures or other body language to communicate
  - none of the above
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**In your opinion, at the hearing the person will be:**

- incapable of making a contribution
- capable of making a limited contribution
- capable of making a significant contribution

The person has the right to attend and participate in the hearing. The person's cognitive impairment or the practical difficulties in bringing them to the hearing are not generally sufficient reasons to prevent their participation. However, if you are concerned that the person's attendance would be detrimental to their health or wellbeing please indicate below and state the reasons for your opinion:

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## **4. Other relevant information**

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Please provide any other information which you believe may assist the Tribunal in determining the application

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## 5. Declaration

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I declare that the information provided and opinions expressed in this form are within my area of expertise.

Name \_\_\_\_\_  
Date \_\_\_\_\_  
Signature \_\_\_\_\_

**Please return all pages of the form directly to NCAT's Guardianship Division or, if appropriate, to the applicant.  
Thank you for supporting NCAT to promote the welfare and interests of people with disabilities.**

### **NCAT Guardianship Division**

Postal address: PO Box K1026, Haymarket NSW 1240

Street address: Level 6 John Maddison Tower, 86-90 Goulburn Street, Sydney

Telephone: (02) 9556 7600 or 1300 006 228  
Interpreter Service (TIS) 13 14 50  
National Relay Service for TTY Users 13 36 77

Email: [gd@ncat.nsw.gov.au](mailto:gd@ncat.nsw.gov.au)

Website: [www.ncat.nsw.gov.au](http://www.ncat.nsw.gov.au)