CONFIDENTIAL

GC-335

ATTORNEY OR PARTY WITHOUT ATTORNEY	STATE BAR NUMBER:	*FOR COURT USE ONLY* *FILE IN CONFIDENTIAL FOLDER*
NAME: FIRM NAME: STREET ADDRESS: CITY: STATE: ZIP CODE: TELEPHONE NO.: FAX NO.: EMAIL ADDRESS: ATTORNEY FOR (*name*):		
SUPERIOR COURT OF CALIFORNIA, COUNTY OF STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME:		
CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(name):* ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE		CASE NUMBER:
CONFIDENTIAL CAPACITY ASSESSMENT AND DECLARATION—PROBATE CONSERVATORSHIP		HEARING DATE: TIME: DEPT. or ROOM:

This form is intended to record the results of a capacity assessment of the person named in item 2, to describe the assessing clinician's conclusions about the person's mental functioning and capacity, and to submit the results and conclusions under oath to the court. The petitioner completes items 1 and 2 to give instructions to the clinician. The clinician completes the remainder of the form.

PETITIONER'S INSTRUCTIONS TO CLINICIAN

1. **Assessments requested.** In addition to completing Parts I and II (pages 2–4), please complete the following items in Part III (pages 5–6) to assess the person's ability to perform the action or capacity to make the decision indicated *(check all that apply):*
   a. ☐ Item 20: Give or withhold informed consent to medical treatment specified in the petition. (Prob. Code, §§ 811, 813, 2357.)
   b. ☐ Item 21: Give or withhold informed consent to medical treatment generally. (*Id.,* §§ 811, 1880–1891, 2355.)
   c. ☐ Item 22: Give or withhold informed consent to placement in a secured-perimeter (locked) residential care facility for the elderly. (*Id.,* §§ 811, 2356.5.)
   d. ☐ Item 23: Give or withhold informed consent to administration of medication appropriate for care and treatment of major neurocognitive disorders (e.g., dementia). (*Id.,* §§ 811, 813, 2356.5.)

   Note to petitioner: Provide a copy of the petition to the clinician who will be assessing the person named in item 2 for the clinician's reference. Do ***not*** attach *Confidential Supplemental Information* (form GC-312).

2. **Person to be assessed**
   a. Name:
   b. Address:
      Telephone number: Email address:
   c. Date of birth:
   d. Highest level of education completed *(grade or degree):*
   e. Marital or partnership status: ☐ single ☐ married/partnered ☐ dissolved ☐ widowed
   f. Preferred language: ☐ speaks ☐ reads ☐ writes

TO THE CLINICIAN: Provide your contact and license information below.

3. a. Name:
   b. Office address:
      Telephone number: Email address:

4. a. ☐ I am a California-licensed physician. License no:
   b. ☐ I am a California-licensed psychologist practicing within the scope of my license. License no:
      ☐ I have at least two years' experience diagnosing major neurocognitive disorders (including dementia).
   c. I have been practicing as a licensed physician or psychologist for years.

Form Adopted for Mandatory Use
Judicial Council of California
GC-335 [Rev. January 1, 2025]

Probate Code, §§ 811–813, 1880–1891, 2356.5, 2357
www.courts.ca.gov

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(name):* ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

Information about the assessment

5. a. The person named in item 2 ☐ is ☐ is ***not*** a patient under my continuing care and treatment.
   b. I have known this person for *(specify length of time in months or years):*

6. a. Date of the examination on which this assessment is based or, if based on multiple examinations, the date I most recently examined the person:
   b. Time spent in most recent examination:

7. My responses to the questions and prompts on this form are based on *(check all that apply):*
   a. ☐ My examination of this person for the purpose of assessing the person's abilities and capacities.
   b. ☐ Multiple examinations of this person for purposes of general health care and medical treatment.
   c. ☐ Administration of standardized examinations or tools that measure the person's mental functioning. All tests administered and dates of administration are listed ☐ below ☐ in Attachment 7c.
   d. ☐ My review of the person's medical records.
   e. ☐ Discussions with other practitioners responsible for providing health care to the person. These discussions are described ☐ below ☐ in Attachment 7e.
   f. ☐ Discussions with team members or other professionals who participated in the person's assessment. These discussions are described ☐ below ☐ in Attachment 7f.
   g. ☐ Discussions with the person's family or friends; names and relationships are given ☐ below ☐ in Attachment 7g.
   h. ☐ Other sources of information, which are described ☐ below ☐ in Attachment 7h.

REPORT OF ASSESSMENT

If a question or prompt does not apply to an ability or capacity checked in item 1 or your assessment does not address a question or prompt, please check the appropriate box in that item or, if there is no box, leave the item blank. Secure or destroy your copy of the petition. Do not send it to the court.

PART I. GENERAL PHYSICAL AND MENTAL HEALTH This part describes the general state of the physical and mental health of the person named in item 2. ☐ Information focused on the effect of the person's health on their mental function is given in items 16–18.

8. **Physical health**
   a. Overall physical health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know
   b. Overall physical health is likely to: ☐ Improve ☐ Remain stable ☐ Deteriorate ☐ I don't know
      ☐ The person should be reevaluated in weeks.
   c. Chronic conditions that require ongoing care and treatment are listed ☐ below ☐ in Attachment 8c.

9. **Mental health**
   a. Overall mental health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know
   b. Overall mental health is likely to: ☐ Improve ☐ Remain stable ☐ Deteriorate ☐ I don't know
      ☐ The person should be reevaluated in weeks.
   c. All known diagnosed mental health disorders (current *Diagnostic and Statistical Manual of Mental Disorders*) are listed ☐ below ☐ in Attachment 9c.

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(name):* ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

PART II. MENTAL FUNCTIONING This part documents the existence and extent of any deficits found by my assessment of the mental functioning of the person described in item 2. Deficits are indicated in items 10–14 as follows:

a = no deficit; **b** = mild deficit; **c** = moderate deficit; **d** = major deficit or no function; **e** = not applicable or not assessed

10. **Alertness and attention** (ability to recognize and react to a stimulus)
    a. Level of arousal or consciousness (deficit may be shown by lethargy, lack of response without constant stimulation, or stupor) ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**
    b. Orientation to:
       (1) Time (When? Year, month, day, hour) ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**
       (2) Place (Where? State, city, address) ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**
       (3) Person (Who? Name, relationship) ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**
       (4) Situation (What? How? Why?) ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**
    c. Ability to attend to and concentrate on tasks (ability to attend to a stimulus; concentrate on a stimulus over brief time periods) ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**

    Notes:

11. **Information processing**
    a. Memory
       (1) Immediate recall ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**
       (2) Short-term memory and learning (the ability to encode, store, and retrieve information) ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**
       (3) Long-term memory (ability to remember information from the past) ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**
    b. Understanding (the ability to receive and accurately process information given in written, spoken, visual, or other media) ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**
    c. Communication (the ability to express oneself and indicate preferences in speech, writing, signs, pictures, etc.) ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**
    d. Visual-spatial reasoning (recognition of familiar objects; spatial perception, problem solving, and design) ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**
    e. Quantitative reasoning (the ability to understand basic quantities and make simple calculations) ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**
    f. Verbal reasoning (the ability to compare options, to reason using abstract concepts, and to reason logically about outcomes) ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**
    g. Executive functioning (the ability to plan, organize, and carry out actions (assuming physical ability) in one's own rational self-interest) ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**

    Notes:

12. **Thought processes**
    a. Organization of thinking (deficit may be demonstrated by severely disorganized, nonsensical, or incoherent thinking) ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**
    b. Correspondence of thoughts to reality (deficit may be demonstrated by hallucinations or delusions) ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**
    c. Control of thoughts (deficit may be demonstrated by uncontrollable, repetitive, or intrusive thoughts) ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**

    Notes:

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(name):* ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

a = no deficit; **b** = mild deficit; **c** = moderate deficit; **d** = major deficit or no function; **e** = not applicable or not assessed

13. **Ability to modulate mood and affect** (deficit may be demonstrated by pervasive and persistent or recurrent mood or affect inappropriate in kind or degree to the circumstances) ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**
    Notes:

14. **Ability to accept and cooperate with appropriate care or assistance** (deficit may be demonstrated by inability to acknowledge illness or disorder, acting without regard for consequences, or inability or refusal to accept appropriate care)
    ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**
    Notes:

15. **Variation** (some or all of the deficits noted above vary in frequency, severity, or duration):
    ☐ Yes ☐ No ☐ I don't know Variation of deficits is described ☐ below ☐ in Attachment 15.

Possible Temporary or Reversible Causes of Mental Function Deficits

16. **Medications**
    a. Is the person currently taking any medication—prescription or nonprescription—that may impair the person's mental functioning?
    ☐ Yes ☐ No ☐ I don't know ☐ Not applicable
    If *yes,* each of those medications, with dosage and treatment indications, is listed ☐ below ☐ in Attachment 16a.

Name	Dosage/Schedule	Indications

    b. An explanation of the nature and severity of the impairment that each listed medication can cause is given
    ☐ below ☐ in Attachment 16b ☐ No medications listed.

17. **Reversible causes** Have temporary or reversible causes of mental impairment been considered, assessed, diagnosed, or treated?
    ☐ Yes ☐ No ☐ I don't know All causes considered are discussed ☐ below ☐ in Attachment 17.

18. **Physical or emotional factors** Are there physical or emotional factors (e.g., hearing, vision, or speech impairment; bereavement; or others) present that could diminish the person's capabilities and that could improve with time, treatment, or assistive devices?
    ☐ Yes ☐ No ☐ I don't know
    ☐ Applicable physical or emotional factors are described ☐ below ☐ in Attachment 18.

Effect on Ability to Perform Everyday Activities

19. In my professional opinion, the mental function deficits, if any, identified in items 10–14 ☐ will ☐ will not significantly impair the person's ability to perform some or all activities of daily living (e.g., eating, cooking, toileting, bathing, dressing) or instrumental activities of daily living (e.g., shopping, scheduling appointments, paying bills, using a credit card or checks, taking medication). More details about specific activities and reasons for my opinion are given *(check all that apply):*
    ☐ below ☐ in Attachment 19 ☐ in the attached *Everyday Activities Attachment* (form GC-335A).

    ☐ I do not have enough information to form an opinion on this issue.

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(name):* ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

PART III. CAPACITY TO GIVE OR WITHHOLD INFORMED CONSENT This part documents my professional conclusions about each issue checked in item 1. The conclusions are based on my assessment of the level of the person's mental functions described in Part II.

20. ☐ **Capacity to give or withhold informed consent to medical treatment specified in the petition** (Probate Code, § 2357.)

The following medical treatment has been recommended for the person *(describe):*

Based on my assessment of the person's applicable mental functions and abilities, it is my professional opinion that:

a. ☐ The person ***has*** the capacity to give or withhold informed consent to the recommended medical treatment because the person can do ***all*** of the following: (1) respond knowingly and intelligently to questions about the treatment; (2) participate in the treatment decision by means of a rational thought process; and (3) understand (A) the nature and seriousness of the diagnosed disorder, (B) the nature of the recommended treatment, (C) the probable degree and duration of and benefits and risks of the recommended treatment, (D) the consequences of lack of treatment, and (E) the nature, risks, and benefits of any reasonable alternatives to the recommended treatment.

b. ☐ The person ***lacks*** the capacity to give or withhold informed consent to the recommended medical treatment because the person ***cannot do at least one*** of the following: (1) respond knowingly and intelligently to questions about the treatment, (2) participate in the treatment decision by means of a rational thought process, or (3) understand at least one of the following: (A) the nature and seriousness of the diagnosed disorder, (B) the nature of the recommended treatment, (C) the probable degree and duration of and benefits and risks of the recommended treatment, (D) the consequences of lack of treatment, or (E) the nature, risks, and benefits of any reasonable alternatives to the recommended treatment.
☐ These conclusions are further explained ☐ below ☐ in Attachment 20b.

c. ☐ I do not have enough information to form an opinion on this issue.

21. ☐ **Capacity to give or withhold informed consent to medical treatment generally** (Probate Code, §§ 811, 1881.)

Based on my assessment of the person's applicable mental functions and abilities, it is my professional opinion that:

a. ☐ The person ***has*** the capacity to give or withhold informed consent to medical treatment because the person can do ***all*** of the following: (1) respond knowingly and intelligently to questions about at least some forms of medical treatment; (2) participate in at least some treatment decisions by means of a rational thought process; and (3) understand (A) the nature and seriousness of some diagnosed disorders, (B) the nature of some recommended treatments, (C) the probable degree and duration of and benefits and risks of at least some forms of treatment, (D) the consequences of lack of at least some forms of treatment, and (E) the nature, risks, and benefits of any reasonable alternatives to at least some forms of treatment.

b. ☐ The person ***lacks*** the capacity to give or withhold informed consent to any form of medical treatment because ***either*** (1) the person is unable to respond knowingly and intelligently to questions about their medical treatment ***or*** (2) the person is unable to participate in treatment decisions by means of a rational thought process, which means the person cannot understand at least one of the following: (A) the nature and seriousness of any illness, disorder, or defect that they have or may develop; (B) the nature of any medical treatment that is or may be recommended by their health-care providers; (C) the probable degree and duration of any benefits and risks of any medical intervention that is or may be recommended by the person's health-care providers and the consequences of lack of treatment; or (D) the nature, risks, and benefits of any reasonable alternatives.

The person's lack of capacity to give or withhold informed consent is linked to one or more mental function deficits described in Part II.
☐ These conclusions are further explained ☐ below ☐ in Attachment 21b.

c. ☐ I do not have enough information to form an opinion on this issue.

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(name):* ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

22. ☐ **Capacity to give or withhold informed consent to placement in a secured-perimeter residential facility for persons with major neurocognitive disorders** (Probate Code, § 2356.5.)
    a. ☐ The person has a major neurocognitive disorder (such as dementia) as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders.* See Part I of this form for more information.
    b. ☐ The person needs or would benefit from placement in a restricted and secure environment for the reasons (for example, wandering, violence, or rejecting care) explained ☐ below ☐ in Attachment 22b.

    c. Based on my assessment of the person's relevant mental functions and abilities, it is my professional opinion that:
        (1) ☐ The person ***has*** the capacity to give or withhold informed consent to this placement.
        (2) ☐ The person ***lacks*** the capacity to give or withhold informed consent to this placement. The mental function deficit or deficits described in Part II significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of giving consent to placement in a restricted, secured-perimeter residential facility.
        ☐ These conclusions are further explained ☐ below ☐ in Attachment 22c.

    d. The proposed placement in a locked or secured-perimeter facility ☐ is ☐ is ***not*** the least restrictive environment appropriate to the person's needs.
    e. ☐ I do not have enough information to form an opinion on this issue.

23. ☐ **Capacity to give or withhold informed consent to administration of medication for treatment of major neurocognitive disorders** (Probate Code, § 2356.5.)
    a. ☐ The person has a major neurocognitive disorder (such as dementia) as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders.* See Part I of this form for more information.
    b. ☐ The person needs or would benefit from appropriate medications for the care and treatment of major neurocognitive disorders (including dementia). Any medications and the need or potential benefit of each are described
    ☐ below ☐ in Attachment 23b.

    c. Based on my assessment of the person's relevant mental functions and abilities, it is my professional opinion that:
        (1) ☐ The person ***has*** the capacity to give or withhold informed consent to the administration of medications appropriate for the care and treatment of major neurocognitive disorders (including dementia).
        (2) ☐ The person ***lacks*** the capacity to give or withhold informed consent to the administration of medications appropriate to the care and treatment of major neurocognitive disorders (including dementia). The mental function deficit or deficits described in Part III significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of giving consent to the administration of medications for the care and treatment of major neurocognitive disorders (including dementia).
        ☐ These conclusions are further explained ☐ below ☐ in Attachment 23c.

    d. ☐ I do not have enough information to form an opinion on this issue.

24. ☐ Other information regarding my assessment of the person's mental functions, any deficits in those functions, and any resulting significant impairments to the person's ability to understand and appreciate the consequences of acts or decisions is given in Attachment 24.

25. Number of pages attached: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

(TYPE OR PRINT NAME)

(SIGNATURE OF DECLARANT)

For your protection and privacy, please press the Clear this Form button after you have printed the form.

Print this form | Save this form | Clear this form