Mental Capacity Assessment Form

Name: **Location:** **D. o B.**	*When In hospital stick hospital label here*

I am completing this assessment form on (date)…….. because the person named above appears to lack capacity at this time
(Assessment context *-Remember assessment of Mental Capacity must be decision and time specific**)***

What is the nature of the decision? *(Details)*

Determination of capacity *(This is specific, not general determination*) See Decision Making flow chart the Mental Capacity Interim policy and the Mental Capacity Act Code of Practice

Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?	Permanent impairment ☐	Temporary impairment ☐	None ☐
Details:			

Can the decision be delayed because the person is likely to regain capacity in the near future?	Yes ☐	Not likely to regain capacity ☐	Not appropriate to delay ☐
Details:			

1. Person has ability to understand information related to the decision to be made?	Yes ☐	No ☐
Details:		
2. Person has ability to retain information related to the decision to be made?	Yes ☐	No ☐
Details:		
3. Person has ability to use or assess the information whilst considering the decision?	Yes ☐	No ☐
Details:		
4. Person has ability to communicate their decision by any means?	Yes ☐	No ☐
Details: state what steps have been taken to achieve communication.		

If you have ticked any of the above questions 1 to 4 as NO then this person lacks capacity at this time

What steps have been taken to enable or assist the person to make or be involved in this decision?
e.g. visual aids

Advance decisions *(Note any documentation referenced)*

Is there any advance decision relevant to this decision?	No ☐ Yes ☐	If yes verbal ☐ *(Detail below)*	Written ☐ *(Detail below)*
Details:			

Best Interests: (What other considerations have been taken into account when assessing this person's best interests)

Section A: Does the person have a Next of Kin/ Person who can inform decision making?	Yes ☐ (see below)	No ☐ (see Section B)

If 'Yes' state :

Name of Persons who can help make decision ……

Relationship……..

Do they have Lasting Power of Attorney or enduring Power of Attorney Yes ☐ No ☐

Date of your discussion with them on your findings……

Did you agree the appropriate way forward for this patient? Yes ☐ No ☐

If 'No' state what help you are going to find to resolve this disagreement:
Details:

NB referral to IMCA may be appropriate if there are Safeguarding Adult issues

Section B: If there is no (unpaid)person who can help inform the decision making process, you must refer to IMCA.

Name of person completing form: ……..

Role …… Date form completed……

Name of person making referral (Decision maker)……
(if different from the person completing the form)

Role of Decision maker …….. Date of referral: ……

Best Interest Decision (The Decision maker must record details of final decision made) **:**