

MENTAL CAPACITY ASSESSMENT

Patient Name:
Hospital Number:

Date of Birth:
Date of Assessment:

Ward/Department:
Date of Admission:

Nature of decision for which capacity is under consideration:

STAGE ONE

Does the patient have an impairment of, or a disturbance in the functioning of the mind or brain?
YES / NO

If **NO** the patient will not lack capacity

If **YES** please indicate the nature or disturbance of the mind or brain.

<input type="checkbox"/>	Forms of mental illness
<input type="checkbox"/>	Dementia
<input type="checkbox"/>	Significant Learning Disability
<input type="checkbox"/>	Delirium
<input type="checkbox"/>	Stroke/Head injury
<input type="checkbox"/>	Confusion, drowsiness or loss of consciousness
<input type="checkbox"/>	Alcohol or drug intoxication
<input type="checkbox"/>	Brain damage
<input type="checkbox"/>	Other (please specify)

Is impairment or disturbance of the mind/brain:

- partial
 temporary
 long term
 not known

STAGE TWO

Does the impairment or disturbance mean that the person is unable to make decision at present?
YES / NO

If **NO** the patient will not lack capacity to make a decision but they may need appropriate help and support.

If **YES** all practical and appropriate support to help the person make the decision must be attempted before carrying out the test for capacity.

Please indicate all interventions used to promote support:

<input type="checkbox"/>	Providing all relevant information
<input type="checkbox"/>	Communicating in an appropriate way
<input type="checkbox"/>	Making the person feel at ease
<input type="checkbox"/>	Support or help from another to enable decision making
<input type="checkbox"/>	Exploring other ways to enable decision making

Proceed to Mental Capacity Test below to assess whether or not a patient is able to make the decision.

Mental Capacity Test (This must be carried out by the appropriate decision maker.)

If any of the following are 'no' the person being assessed lacks capacity for that decision)

On the balance of probability:

1. Does the patient **understand** the information relevant to the decision for assessment, care, treatment, residential care? **YES / NO**

2. Is the patient able to **retain** the information long enough to make a decision about their assessment, care, treatment, residential care? **YES / NO**

3. Is the patient able to **weigh** that information as part of the process of making the decision? **YES / NO**

4. Is the patient able to **communicate** their decision? **YES / NO**
(Speech, sign language, other means)

Conclusion

Based on my assessment and following consultation with appropriate others, on the balance of probability, the above named has capacity/lacks capacity to consent to the following decision for care and treatment:

Further 'best interest' assessment **is required / is not required** for care and treatment under the MCA 2005. If required, date of completion of best interest assessment _____
(Best interest assessment to be attached to capacity assessment when completed.)

Signed Decision maker	
Name	
Job Title	