**Mental Capacity Assessment Form**

This form should be completed by an appropriate professional from Health or Social Care who knows the person best where there is concern that a person may lack capacity to make a specific decision at the time it needs to be made.

**Date of Assessment: ………… Name of Person: …………………………………………**

**Ref No: ……………… Address: ……………………………………………………**

**Postcode: ………………………………………………….**

**Location where the assessment is being carried out: ………………………………………..**

|  |
| --- |
| **1. What is the nature of the impairment or disturbance to the person’s mind or brain** |
|  |

|  |  |
| --- | --- |
| **2. What is the Decision to be made:** | |
| Full details of the issue on which a decision is required *(Note that capacity is decision and time specific and if there are several issues to be decided, each one must be considered separately.)* |  |
|  |  |
| **3. Support:** | |
| Explain what support has been provided in order to help the person make his / her own decision? |  |

|  |  |
| --- | --- |
| **4. Mental Capacity:** | |
| **Is the Person able to:** | |
| **UNDERSTAND** the information relevant to the decision? | **Yes [ ] No [ ]**  ***Please describe how you have reached your decision:*** |
| **RETAIN** the information long enough to make the decision? | **Yes [ ] No [ ]**  ***Please describe how you have reached your decision:*** |
| **USE the** information in the process of making the decision? *(i.e. weigh up the pro’s and con’s)* | **Yes [ ] No [ ]**  ***Please describe how you have reached your decision:*** |
| **COMMUNICATE** their decision to you (by any means) | **Yes [ ] No [ ]**  ***Please describe how you have reached your decision:*** |

|  |  |
| --- | --- |
| **5. Conclusions:** | |
| What is **YOUR** reasonable conclusion regarding the person’s capacity to make the specific decision described above? Please tick appropriate box and give a brief explanation.  **PLEASE NOTE THERE WOULD HAVE TO BE A NEGATIVE OUTCOME IN ONE OR MORE OF THE DOMAINS IN ORDER FOR THE CONCLUSION TO BE THE PERSON LACKS CAPACITY TO MAKE THE DECISION** | [ ] The person has the mental capacity to make the decision  [ ] The person lacks the mental capacity (at this time) to make the decision |

|  |  |
| --- | --- |
| **6. Assessment completed by:** | |
| **Name:** |  |
| **Job Title:** |  |
| **Signature:** |  |
| **Date Completed:** |  |
| **Time Completed:** |  |

**Please return this form to the relevant site:**

|  |  |
| --- | --- |
| **Heald Green:**  St Ann’s Hospice Admissions Office, St Ann’s Road  North, Heald Green, Cheadle, SK8 3SZ  Phone: 0161 498 3608  **Email:** nehgm.admissions-hg@nhs.net | **Little Hulton:**  St Ann’s Hospice Admissions Office, Meadowsweet  Lane, Off Peel Lane, Little Hulton, Worsley, M28 0FE  Phone: 0161 702 5408  **Email:** stan.admissions-lh@nhs.net |

For information about how St Ann’s Hospice processes personal information, see our privacy notice here: <https://www.sah.org.uk/privacy-policy/>