Milton Keynes Hospital NHS Foundation Trust NHS WeCARE

Mental Capacity Assessment Form

For staff use only:
Surname:
Forenames:
Date of birth:
Hospital No:
or affix patient label

Ward/Department	Date of Admission: / /	Date/ Time of Assessment:

What is the specific decision to be made?

Does the patient have an impairment of or a disturbance in the functioning of the mind or brain?	Yes	No
If **NO** then the patient will not lack capacity.		
If **YES** what is the nature of impairment or disturbance of the mind or brain? Partial □ Temporary □ or Long-term □.		
Please give details of the impairment or disturbance in the functioning of the mind or brain Forms of mental illness □ Dementia □ Significant Learning Disabilities □ Delirium □ Stroke/Head injury □ Brain damage □ Confusion drowsiness or loss of consciousness □ Alcohol or drug intoxication □ Any other please specify □ ……		

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

Does the impairment or disturbance mean that the person is unable to make a decision at present?	Yes	No
If **NO** the patient will not lack capacity to make a decision but may need appropriate help and support.		
If **YES** then all practical / appropriate support to help the person make the decision must be attempted before carrying out the test for capacity. Please tick one or more of the following practical / appropriate support provided.		
Providing relevant information □ Communicating in an appropriate way □ Making the person feel at ease □ Supporting the person □ Exploring what other ways are there to enable decision making □		

Proceed to answer four questions over the page to assess whether or not the patient is able to make a decision.

Milton Keynes Hospital NHS
NHS Foundation Trust

WeCARE

For staff use only:
Surname:
Forenames:
Date of birth:
Hospital No:
or affix patient label

On the balance of probability, please circle the answer to the question, which applies to the patient under assessment.			
1	Does the patient **understand** the relevant information about the decision for their admission for assessment, care and treatment or discharge?	**Yes**	**No**
2	Is the patient able to **retain** the information/explanation long enough to make the decision about their admission for assessment, care and treatment, or discharge?	**Yes**	**No**
3	Is the patient able to **weigh** the information in the balance as part of the process of making the decision for their admission for care and treatment or discharge?	**Yes**	**No**
4	Is the patient able to **communicate** their decision either by speech, sign language or by any other means?	**Yes**	**No**

For significant decisions please document in the patients notes details of the assessment: i.e. how you came to your decision that they could/ not understand or retain the information etc.

Is there a family member/ friend/ LPA who can act in the patient's best interest. (If LPA please clarify type)	**Yes**	**No**
Name, Relationship and Contact details of this person: IMCA Service Contacted Yes/No Date Contacted / / First Visit by IMCA / /		

Conclusion:

□ In my opinion, based on my own assessment, and following consultation with appropriate others, the above-named **has capacity / lacks capacity** to consent to the following decision for care and treatment:

……

……

□ Further assessment is **required/not required** for care and treatment under the MCA 2005.

Name of Assessor: **(Decision Maker)** **Signature**	**Job Title:**

Please note that if condition changes a repeat MCA assessment may be required for this decision.