# Mental Capacity Assessment Tool

Client Name

Client Address: ………..

Case Manager: ………..

Date: DD/MM/YYYY

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| Decision that needs to be made |
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| Are there any alternative decisions that could be made? |
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| Does the client agree to participate in the capacity assessment: (If not is the client unwilling or unable)? |
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| If client is under the Court of Protection, If yes name and role of deputy |
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| Client’s Relevant Others  | Relationship to Client |
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| Is a specialist report required? If so, why? |
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| Question | Yes and evidence | No and evidence |
| Does the client understand the information about the decision to be made? |  |  |
| Is the client able to retain the information in his mind? |  |  |
| Can the client use or weigh up that information as part of the decision-making process? |  |  |
| Is the client able to communicate the decision in any way? |  |  |

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| Describe assessment process |
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| **Is there an impairment or disturbance in the functioning of the mind?** |
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| Is the client’s inability to make a decision because of the impairment or disturbance in the functioning of their mind or brain? |
| Diagnosis / symptoms |

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| Who was consulted  | Their view |
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| Does the client have capacity re: this issue? |
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Case Manager Signature: ………

Date: DD/MM/YYYY