**Assessment of capacity**

|  |
| --- |
| Date Completed: |
| NHS No: |

Full name of the person to whom the assessment relates

(this is the name of the person who lacks, or is alleged to lack, capacity)

**Please read first:**

* **The principles of the Mental Capacity Act require that an assumption is made that every person has capacity unless it is established that he lacks capacity**
* **A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success**
* **A person is not to be treated as unable to make a decision merely because he makes an unwise decision**
* **The assessment of capacity should be time and decision specific. As part of the assessment ensure you are clear about what decision you are being asked to assess the persons capacity to make and when that decision needs to be made.**
* **The practitioner completing the form should be a registered practitioner:**
	+ **Medical practitioner**
	+ **Psychiatrist**
	+ **Approved mental health professional**
	+ **Social worker**
	+ **Psychologist**
	+ **Nurse**
	+ **Occupational therapist**

**About the Practitioner**

|  |  |
| --- | --- |
| Full Name |  |
| Occupation |  |
| Professional Address |  |
| Work Contact Number |  |
| Work email address |  |

**About the Person whose capacity you are assessing**

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Date of Birth |  |
| Gender | Male |  | Female |  |

**About the decision**

|  |  |
| --- | --- |
| What is the decision you are assessing the individuals capacity to make | Should this individual be tested, by way of swabbing (which may be a nasal swab, a throat swab or a nasopharyngeal swab), for novel coronavirus (Covid-19)? |
| When will the decision be made | Between 12 May 2020 and 12 November 2020 |
| Is the resident likely to have fluctuating capacity in that time? | Yes |  | No |  |
| How would the decision benefit the person to whom this assessment relates | In the event that the individual were to swab negative for the virus they may not need to be placed under quite such significant restrictions on their movement depending on the circumstances in the home. This would also allow for routine appointments at the hospital and GP to continue unhindered. |
| What is your connection or relationship to the person to whom the assessment relates |  |

**The Assessment**

|  |  |
| --- | --- |
| The person to whom the application relates has the following impairment of, or disturbance in the functioning of, the mind or brain. Where this impairment or disturbance arises out of a specific diagnosis, please set out the diagnosis: |  |
| Date of diagnosis |  |
| In your opinion does this impairment or disturbance of the functioning of the mind or brain mean that the individual in question does not have capacity to make a decision about whether or not they should be tested for Covid-19 by way of a swab? | Yes |  | No |  |

**Reasons for the Assessment Outcome:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Can the individual understand information relevant to the decision? | Yes |  | No |  |
| **Details of reason for above answer:** |
| Can the individual retain the information relevant to the decision? | Yes |  | No |  |
| **Details of reason for above answer:** |
| Can the individual weigh the information relevant to the decision? | Yes |  | No |  |
| **Details of reason for above answer:** |
| Can the individual communicate their decision by any means at all? | Yes |  | No |  |
| **Details of reason for above answer:** |