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| **REPORT ON MENTAL INCAPACITY FOR AUTOMATIC REVIEW OF ORDER** |
| **This form gathers information from a Doctor, Director of Nursing,**  **Hostel Manager or Professional Carer** |

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| --- | --- |
| **Capacity report for:** |  |
| **Case number:** |  |
| **Form issued to:**  **Case officer:** |  |

1. **Does [$ProtectedPersonFullName] still have a mental incapacity?**

Yes

No

1. **Specifics of condition**

Please tick

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Dementia** | **Intellectual  disability** | **Brain damage   from trauma** | **Mental health  condition** | **Other (Please specify)** |

|  |  |
| --- | --- |
| Specific diagnosis and deficits *(attach another sheet if necessary)*: | |
|  | |
| Approximately how long has the person had the condition? |  |

Is the person’s condition  **Mild**  **Moderate**  **Severe**

Is the person’s condition  **Static**  **Fluctuating**  **Deteriorating**  **Likely to Improve**

1. **How does it affect their ability to make significant decisions or manage their own affairs?**
2. **Other relevant information in relation to [$ProtectedPersonFullName]’s mental incapacity:**
3. **Clinician’s stamp** (if you are a clinician and do not have a stamp write your name, clinical role and work address below)