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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)