M

South Central Ambulance Service NHS
NHS Foundation Trust

Use Capital Letters and Black Biro

Mental Capacity Act 2005 and Assessment Form CAS150 V2.3

Incident Date	Incident Number	PRF Unique Number	Call Time
/ /			:

Patient Surname | Patient First Name

Date of Birth / / | Age - Years | ○ Male ○ Female | Patients Postcode

NHS Number

Surname of Nominee / Guardian (where appropriate) | Title | Nominee / Guardian Signature

Already in contact with support service? ○ Yes ○ No | If Yes, complete details: Name of Service and Contact

Who called for assistance? ○ Patient ○ Police ○ Public ○ Relative ○ GP ○ Other

Police ID Number | Location of Patient

Use continuation sheet(s) to document a brief outline of events preceding incident & any other comments (refer to medical model).

Mental Capacity Assessment Functional Test

1	Is the patient able to understand the information relevant to the decision - can they tell you about it?	○ Yes	○ No
2	Can the patient retain that information - can they accurately describe it to you?	○ Yes	○ No
3	Can the patient use, or weigh up the information, as part of the decision making process? * *see important note below*	○ Yes	○ No
4	Can the patient communicate their decision to you?	○ Yes	○ No

NB - If the answer to any question above is NO then you may reasonably believe that the patient lacks capacity at this moment in time.

JRCALC Suicide and Self Harm Risk Assessment N/A ○

	Yes	No
Is the patient male?	○	○
Is the patient 19 years old or younger?	○	○
Is the patient 45 years old or older?	○	○
Is the patient showing signs of depression / hopelessness?	○	○
Has the patient experienced previous attempts at suicide / self-harm?	○	○
Does the patient have a history of excessive alcohol/illicit drug use?	○	○
Is the patient's rational thinking absent (i.e. are they experiencing hallucinations or delusions)?	○	○
Is the patient single / separated / divorced / widowed?	○	○
Has the patient experienced an organised or serious attempt at suicide?'	○	○
Does the patient have no close / reliable family, job or active religious affiliation?	○	○
Is the patient determined to repeat actions or ambivalent about their future?	○	○

< 3 = Low Risk 3 - 6 = Medium Risk >6 = High Risk Total 'Yes'

*** IMPORTANT NOTE**

For threatened/attempted suicide, complete the JRCALC Suicide and Self Harm Risk Assessment Tool. If the score is 3, or more, consider if the mental capacity of the person has been impaired by the effects of alcohol, drugs, or by that person's emotional distress. If so, you must be satisfied that these temporary factors are operating to such a degree that the assumption of mental capacity is overridden.

There is a legal understanding that patients in such circumstances may not truly be able to weigh up the information needed to make a decision at that time. If so, the answer to Q3 in the Functional Test is 'no' and should be recorded as such.

Has the patient consumed drugs or alcohol within the past 24 hours?

○ Yes ○ No ○ Unknown

If YES, please detail what was consumed and when it was consumed

Proposed Intervention? (This should be the least restrictive option)

I have completed an assessment of capacity and reasonably believe (on the balance of probabilities) that the patient ○ DOES ○ DOES NOT have capacity to make the decision required at this time.

Where the patient lacks capacity: I believe that the proposed care/treatment is in the patient's best interests and is the least restrictive intervention, proportionate to the risks of not receiving further care/treatment at this time.

Completed By PIN | Call Sign | Hospital Code | Print / Sign Name

Top Copy to be returned to SCAS, Bottom Copy to remain with the patient

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