smiles group | domiciliary

Assessment of capacity form

Assessment of capacity for proposed dental treatment/decision.

Name:	DOB:
Address:	
Postcode:	Tel No:
GP Name:	Practice: Tel No:
Next of Kin:	
Contact Details::	

Summary of proposed treatment plan/decision to be made

....

....

Is the proposed treatment plan/decision unusual? Yes ☐ No ☐ Don't know ☐

If yes, state why

....

....

Does the patient have a condition/impairment which may affect their capacity to consent to dental treatment?

Yes ☐ No ☐ Don't know ☐

If yes, record reason for impaired capcity (e.g. learning disability, dementia, brain injury, stroke etc).

....

Is the impaired capacity likely to be temporary or permanent?

Temporary* ☐ Permanent ☐ Don't know ☐

* If temporary, defer non-urgent treatment until capacity returns if possible

Assessment of capacity

Can the patient understand the information given to them about their treatment?

Yes ☐ No ☐ Don't know ☐

Can the patient retain that information long enough to be able to make the decision?

Yes ☐ No ☐ Don't know ☐

Can the patient weigh up the information available to make the decision?

Yes ☐ No ☐ Don't know ☐

smiles group | domiciliary

Can the patient communicate their decision (whether by talking, sign language or any other means)?

Yes ☐ No ☐ Don't know ☐

Was consultation with other professionals required to assess capacity? Yes ☐ No ☐

If yes, record name and status

....

Does the patient have mental capacity? Yes ☐ No ☐ Don't know ☐

Best interest check list if th patient lacks capacity

What methods have been used to involve the person who lacks capacity in making the decision?

....

....

Has the patient's past or present wishes, feelings and beliefs been taken into consideration?

Yes ☐ No ☐ Don't know ☐

Have others been consulted regarding the treatment/decision?

Yes ☐ No ☐ Don't know ☐

Names and relationship to patient who can act in service user's best interest contacted?

....

....

Does the patient have an appointed Power of Attorney or Court of Protection appointed deputy?

Yes ☐ No ☐ Don't know ☐

If yes, record any name and date contacted?

....

Are you aware of any advanced directives regarding dental/personal care?

Yes ☐ No ☐ Don't know ☐

If the patient does not have any personal or legal advocates, do you need to involve the Independent Mental Capacity Advocate (IMCA)

Yes ☐ No ☐ Don't know ☐

If yes provide name of IMCA ....

Date consulted ....

Outcome of consultation ....

....

....

Signature: .... Designation: ....

Name: .... Date: ....