For adults who lack the capacity to consent to investigation or treatment

Please fax or send a copy of this form to the RCHT Safeguarding Adults Team on (fax) 01872 252658
Further help and advice is available on the RCHT website or via the above team on 07789 876247 (or ext 2446)

<table>
<thead>
<tr>
<th>Details of family and/or friends</th>
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<tbody>
<tr>
<td>Next of kin:</td>
<td>Relationship:</td>
</tr>
<tr>
<td>Home telephone:</td>
<td>Mobile telephone:</td>
</tr>
<tr>
<td>Appropriate to consult?</td>
<td>Yes</td>
</tr>
<tr>
<td>Alternative contact:</td>
<td>Relationship:</td>
</tr>
<tr>
<td>Home telephone:</td>
<td>Mobile telephone:</td>
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<tr>
<td>Appropriate to consult?</td>
<td>Yes</td>
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**Independent Mental Capacity Advocate (IMCA)**

For decisions about serious medical treatment where there are no friends, relatives or unpaid carers to act as an advocate for the patient, an Independent Mental Capacity Advocate (IMCA) should be appointed (Note that this is often not possible in an emergency situation). For further advice see the RCHT consent website.

Does the patient require an IMCA? Yes | No | Date of referral:

*If an IMCA is appointed please complete section I page 4*

**Key roles:** Please record all details known

Has an enduring **Lasting Power of Attorney** for Health and welfare been appointed? Yes | No | Not aware

Name: | Telephone:

Has a **Court of Protection Deputy** been appointed for this patient? Yes | No | Not aware

Name: | Telephone:

*If an attorney or deputy has been appointed please ensure they complete section H page 4*

**Advanced Decision**

Is there an **Advanced Decision** relevant to the decision being discussed? Yes | No | Not aware

If yes, what is the type? Written | Verbal | Date of advance decision:
This is an important legal document - All sections MUST be completed by the health professional proposing the procedure.

A Details of procedure or treatment proposed

(See guidance to health professionals on RCHT consent website for details of situations where court approval must first be sought)

This box not to be left blank

B Assessment of patient’s capacity to make a decision about the above treatment (in accordance with the Mental Capacity Act)

I confirm that the patient lacks capacity to give or withhold consent to this procedure or course of treatment, because of an impairment of the mind or brain or disturbance affecting the way their mind or brain works. The patient is unable to (please tick all that apply):

- understand information about the procedure or course of treatment
- retain that information in their mind
- use or weigh that information as part of the decision-making process, or
- communicate their decision (by talking, using sign language or any other means).

Please summarise the nature of the impairment or disturbance: For example conditions affecting cognitive function such as drugs or alcohol, trauma, mental disorder, learning disability or dementia.

This box not to be left blank

C Temporary lack of capacity

Is the patient’s lack of capacity temporary? □ Yes □ No

If lack of capacity is likely to be temporary, treatment cannot wait until the patient regains capacity because:

D Dementia

Do you understand the patient to be suffering from a form of dementia? □ Yes □ No

Has a dementia assessment been recorded in the patients notes? □ Yes □ No

(If this patient has dementia, a dementia screen must be completed and recorded in the notes)

E Advanced directive - Please tick to affirm this statement □

As far as reasonably possible, I have considered the patient’s past and present wishes and feelings (in particular if they have been written down) and any beliefs and values that would be likely to influence this decision. I am not aware of the patient having refused this procedure in a valid advance decision and have taken reasonable steps to confirm this.

F Statement of best interest

I have considered the patient’s best interests in accordance with the requirements of the Mental capacity Act and believe the procedure to be in their best interests because:

This box not to be left blank
G  Involvement of those close to the patient

The final responsibility for determining whether a procedure is in the best interest of this patient lies with the health professional performing the procedure (unless the patient has an attorney or deputy, see section H). However, you must consult with those close to the patient (eg spouse/partner, family or friends, carer, supporter or advocate) as far as is practicable and as appropriate. Note that if there is a dispute or the case is complex consider a Best Interest Meeting (see section J).

To be signed by a person or persons close to the patient, if they wish.

I have been involved in a discussion with the relevant health professionals over the treatment of:

______________________________________ (patient’s name).

I understand that he/she is unable to give their own consent, based on the criteria set out in this form.

I also understand that treatment can lawfully be provided if it is in his/her best interests to receive it.

Any other comments (including any concerns about the decision):

Name: __________________________________ Relationship to patient: ____________________________
Signature: ____________________________ Date: ____________________________

Name: __________________________________ Relationship to patient: ____________________________
Signature: ____________________________ Date: ____________________________

Additional contact details if different from page one:

If a person close to the patient was not available in person, has this matter been discussed in any other way (eg over the telephone)? □ Yes □ No

Please record below details of any telephone discussion. If it has not been possible to discuss the planned treatment with those close to the patient, please record the reason:

H  Signature of health professional proposing treatment

I have assessed and documented the reasons why the patient lacks capacity to give consent for this procedure.

I have/have not sought a second opinion.

Where possible and appropriate I have discussed the patient’s condition with those close to him/her and taken their knowledge of the patient’s views and beliefs into account in determining his/her best interests.

Name: __________________________________ Date: ____________________________
Signature: ____________________________ Job title: ____________________________

If a second opinion has been sought, she/he should sign below to confirm agreement

Name: __________________________________ Date: ____________________________
Signature: ____________________________ Job title: ____________________________
## Lasting power of attorney or court of protection deputy

*If a Lasting Power of Attorney or a Court Appointed Deputy has been authorised to make decisions about the patient’s health, the attorney or deputy will have the final responsibility for determining whether this procedure is in the patient’s best interests and must sign below.*

**Signature of attorney or deputy**

I have been authorised to make decisions about the procedure in question under an enduring/lasting power of Attorney / as a Court Appointed Deputy (delete as appropriate).

I have considered the relevant circumstances relating to the decision in question (see section C) and believe the procedure to be in the patient’s best interests.

Any other comments (including the circumstances considered in assessing the patient’s best interests):

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Signature:</td>
<td>Relationship to patient:</td>
</tr>
<tr>
<td>Address if different to patient:</td>
<td></td>
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</tbody>
</table>

## Independent Mental Capacity Advocate (IMCA)

Please provide details if an IMCA has been appointed. The IMCA should also sign below.

Details:

<table>
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## Best Interest Meeting

An *best interest meeting may not need to be held if all interested parties agree and it is clearly documented that the proposed treatment is in the best interests of the patient. However if there is a dispute or the case is particularly complex it may be useful to hold a meeting to discuss the best interest decision and plan the admission.*

Best interest meeting required?  ☐ Yes  ☐ No  If yes, date of meeting: ______________________

Please ensure minutes of any best interest meetings are filed alongside this consent form in the patient’s notes.