

**CAPACITY ASSESSMENT**

**(Section 57, Mental Health Act 2001)**

Service User Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MRN: \_\_\_\_\_\_\_\_\_

Ward: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

Details of how this treatment will benefit the patient:

Details of the discussion with the patient and the patient’s views:

Details of any assistance given to the patient:

Details of your assessment of the patient’s capacity to consent:

Witness signature (Consultant Psychiatrist): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_