ASSESSMENT OF MENTAL CAPACITY FORM

NAME OF THE PERSON TO BE ASSESSED _____

NRIC/FIN/PASSPORT NO. _____

DATE OF ASSESSMENT _____

DD / MM / YYYY

PLEASE READ FIRST

1. Part A of this form must be completed by the person requesting a mental capacity assessment, whether of himself/herself or of another person, before the assessment takes place so that the accredited medical practitioner can read those details and understand the reasons why the assessment is sought.

2. Part B of this form must be completed by the accredited medical practitioner who is conducting the assessment.

3. The accredited medical practitioner conducting this assessment should not:
   - be related in any way to the person to be assessed or
   - have any interest (financial or otherwise) in any matter concerning the person to be assessed.

4. The accredited medical practitioner may charge a fee to conduct the assessment and complete the form.

5. Please be informed that the person could be referred to another medical practitioner if the earlier assessment is deemed insufficient.

6. Please read the Guidance Notes at the end of this form to assist you when you complete this form.

7. If you need any further assistance, please check the website of the Office of Public Guardian at [www.publicguardian.gov.sg] or call [telephone number].

PART A – TO BE COMPLETED AND GIVEN TO THE ACCREDITED MEDICAL PRACTITIONER BEFORE THE PERSON TO BE ASSESSED IS EXAMINED BY THE ACCREDITED MEDICAL PRACTITIONER

1. Particulars of the person to be assessed (the Patient)

1.1 Title ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other _____

1.2 Name _____

1.3 Address _____

1.4 NRIC/FIN/Passport No _____ 1.5 Date of Birth _____
DD/MM/YYYY

1.6 Tel No _____ 1.7 Hand Phone No _____

1.8 The Patient has/does not have* a valid Lasting Power of Attorney registered with the Office of Public Guardian.
(*Delete as appropriate)

2. Particulars of the person requesting the mental capacity assessment (if not the Patient)

2.1 Title ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other _____

2.2 Name _____

2.3 Address _____

2.4 NRIC/FIN/Passport No _____

2.5 Tel No _____ 2.6 Hand Phone No _____

2.7 Relationship to the Patient: _____

3. Reasons for seeking the mental capacity assessment

3.1 Please state the purpose of the assessment and how it would benefit the Patient

Purpose for Assessment
☐ To determine if the Patient has mental capacity to make a lasting power of attorney.
☐ To determine if the Patient has mental capacity to make the decision detailed in 3.2.
☐ The donee of a lasting power of attorney made by the Patient intends to make the decision detailed in 3.2 on the Patient's behalf if the Patient lacks capacity to make the decision.
☐ For application to court to make the decision detailed in 3.2 for Patient.[1]
☐ For application to court to appoint a deputy for the Patient.[1]
☐ Others (please specify)

[1] *These purposes are still tentative items to the confirmed.*

3.2 What is/are the decision(s) that the Patient needs to make?

Patient needs to make decision about	**Please tick**
Managing himself/herself and his/her Property & Affairs	☐ Yes ☐ No

OR

Patient needs to make the following specific decisions relating to:	**Please tick**
Operating his/her bank accounts	☐ Yes ☐ No
His/her CPF Matters	☐ Yes ☐ No
His/her Property Related Transaction	☐ Yes ☐ No
Legal Proceedings (provide brief description)	☐ Yes ☐ No
Where he/she is to live	☐ Yes ☐ No
Others (please specify)	☐ Yes ☐ No

3.3 Please state how the decision would benefit the Patient

_____

_____

_____

_____

4. Previous assessments of mental capacity

4.1 Has the Patient had his/her mental capacity assessed previously by another medical practitioner? ☐ Yes ☐ No

If yes, please bring the Assessment of Mental Capacity forms which relate to those assessments with you and show them to the medical practitioner.

5. Medical history of patient relating to mental capacity

5.1 The Patient has been diagnosed with (please tick):

☐ Stroke ☐ Parkinson's disease ☐ Brain injury (incl. vegetative state) ☐ Dementia

☐ Other conditions (such as intellectual disabilities) [SEE NOTE 1]:

_____

For each condition(s) ticked, please give details

_____

_____

☐ Not applicable

5.2 Onset of the condition estimated from _____
MM/YYYY

6. Addressee of the Certificate on Mental Capacity

The Certificate of Mental Capacity is to be addressed to

_____

7. Further Information

Please provide further information about the circumstances or the medical history of the Patient that would help the medical practitioner to make a mental capacity assessment in relation to the decision that has to be made by the Patient. [SEE NOTE 2]

DECLARATION

Complete Declaration A OR B as appropriate.
Sign and date **Declaration A** if you are the Patient seeking the mental capacity assessment and you have filled out this form.
Sign and date **Declaration B** if you are the person seeking the assessment for the Patient.

DECLARATION A

I certify that the information I have provided is true and accurate to the best of my knowledge.

_____ _____

NAME & SIGNATURE **DATE**

DECLARATION B

1. I am seeking a mental capacity assessment of the Patient because I believe that he/she does not have the mental capacity to make the decision(s) detailed in Item 3.2.
2. I have made every effort to communicate with and to help the Patient make a decision.
3. I have provided the medical practitioner making the assessment with copies of any previous mental capacity assessments conducted by other medical practitioners on the Patient.
I certify that the information I have provided is true and accurate to the best of my knowledge.

_____ _____

NAME & SIGNATURE **DATE**

PART B – TO BE COMPLETED BY THE ACCREDITED MEDICAL PRACTITIONER MAKING THE MENTAL CAPACITY ASSESSMENT

8. Particulars of the accredited medical practitioner

8.1 Name _____

8.2 Clinic/Institution _____

8.3 Address _____

8.4 Tel No _____ 8.5 Fax No _____

8.6 MCR No _____

8.7 Please answer (a) or (b) [SEE NOTE 3]

(a) The Patient has been my patient since _____ (DD/MM/YYYY) and I last assessed him/her on _____ (DD/MM/YYYY)

(b) The Patient was referred to me by _____

9. Mental capacity assessment [SEE NOTE 4]

9.1 (a) Does the Patient suffer from an impairment of, or disturbance in, the functioning of the mind or brain?

☐ Yes (please provide details) ☐ No

_____

_____

(b) If yes, is the condition permanent or temporary?

☐ Permanent ☐ Temporary

9.2 Can the Patient understand information regarding the decision(s) detailed in 3.2?

☐ Yes ☐ No (please provide details)

_____

_____

9.3 Can the Patient retain information regarding the decision(s) detailed in 3.2?

☐ Yes ☐ No (please provide details)

_____

_____

9.4 Can the Patient use or assess information regarding the decision(s) detailed in 3.2?

☐ Yes ☐ No (please provide details)

_____

_____

9.5 Can the Patient communicate his/her decision(s) (whether by talking, using sign language or any other means)?

☐ Yes ☐ No (please provide details)

_____

_____

9.6 (a) The Patient I have assessed has the mental capacity to make the decision(s) detailed in 3.2 at the particular time of assessment.

☐ Yes ☐ No

(b) If No, is the Patient likely to regain mental capacity?

☐ Yes (estimate when the Patient may regain capacity & state reasons)

☐ No/ Not Likely

_____

_____

9.7 Are you aware of anyone else who has a different view to you regarding the mental capacity of the Patient?

☐ Yes (please give details) ☐ No

9.8 Do you have any comments or recommendations about the future care of the Patient? [To be answered only if the decision to which this assessment relates concerns the Patient's care arrangements]

_____

_____

_____

_____

_____

_____

CONCLUSION

Based on my assessment on the patient, I conclude that,
(PLEASE TICK ONE)

☐ The Patient has the mental capacity to make the decisions detailed in para 3.2

☐ The Patient lacks mental capacity to make the decisions detailed in para 3.2

☐ I am uncertain about the Patient's mental capacity. Specialist opinion is recommended

9.9. Other comments (if any):

DECLARATION:

1. **My assessment of the Patient has not been biased by age, appearance or condition.**
2. **I have made every effort to communicate with the Patient.**
3. **Neither my family members, friends nor I have any interest (financial or otherwise) in any matter concerning the Patient.**

NAME & MRC NUMBER OF DOCTOR **DATE**

GUIDANCE NOTES

NOTE 1 – Medical history of Patient

Below is a list of operational definitions for the medical conditions detailed at 5.1.

Stroke

Loss of brain function caused by occlusion or rupture of blood vessel to the brain. There may be loss of cognitive function.

Intellectual disability

Disability characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the patient attains the age of 18.

Dementia

Group of conditions characterized by progressive loss of memory and intellectual functions that is serious enough to interfere with performing the tasks of daily life. Dementia can occur to anyone at any age from an injury or from oxygen deprivation, although it is most commonly associated with aging.

Parkinson's disease

Disorder of the brain characterised by shaking (tremors) and difficulty with walking, movement, and coordination. In some patients there is also dementia.

Brain injury (including vegetative state)

Any injury to the brain regardless of age at onset, whether mechanical or infectious in origin, including brain trauma, brain damage and traumatic head injury. The results of the injury are expected to continue indefinitely and constitute a substantial handicap to the individual. This directly results in any one or more of the following: attention impairment, cognition impairment, language impairment, memory impairment, conduct disorder and motor disorder. This definition includes the vegetative state, which is defined as a wakeful unconscious state that lasts longer than four weeks.

Mental disorder (synonym mental illness)

Any of various conditions characterized by impairment of an individual's normal cognitive, emotional, or behavioral functioning, and caused by social, psychological, biochemical, genetic, or other factors, such as infection or head trauma.

Learning disability

A number of disorders that may affect the acquisition, organization, retention, understanding or use of verbal or nonverbal information. These disorders affect learning in individuals who otherwise demonstrate at least average abilities essential for thinking and/or reasoning. As such, learning disabilities are distinct from global intellectual deficiency.

NOTE 2 – Further information

An example of further information includes details of the general financial circumstances of the person to be assessed if the person making the application is concerned about how the person to be assessed is managing his or her financial affairs. This will assist the medical practitioner to evaluate the decision-making capability of the person to be assessed in relation to the specific question at hand.

NOTE 3 – Date of first assessment

For item 7.7(a), if the person to be assessed is a new Patient, please enter today's date in the first space and "N/A" in the second space.

NOTE 4 – Person to be assessed has mental capacity to make the specific decision

Section 4(1) of the Mental Capacity Act states that:

> "For the purpose of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain."

If you have assessed that the Patient has no impairment of, or a disturbance in the functioning of, the mind or brain, the Patient should have mental capacity to make the decision.