

## Documentation Guidance for Decision Making Capacity Assessments

Begin with the end in mind: Be clear ahead of the visit on what type of documentation is needed. A **summary letter** (AKA case summary or case letter) can be 1-2 pages in length. A more detailed **assessment report** (AKA case report or detailed report) may be 5-10 pages or more, depending on the situation's complexity. Be sure to explain any acronyms and clinical terms using language and concepts that the reader can understand. Below are recommendations for information to include in your documentation:

### Context

- Date, time, duration, location of visit, relevant identifiers of person assessed (DOB), who else was present.
- Summary of your current licensure, credentials, and experience, and any factors that limited your ability to offer opinions on this case.
- Description of who requested the assessment, their role, and contact info, and who is paying for the service.
- Statement describing the notification and informed consent processes and the person's understanding.
- Summary of the problem or type of capacity at question, along with related legal standard/laws.

### Assessment and related information

- Summary of the visit discussion, with direct quotes and description of the person's response style.
- Description of medical history, current conditions and medications, psychosocial and education/work history, relationship/family history and current involvement, living situation, and supports/assistance.
- Assessment of the person's present and historical cognitive and executive functioning; emotional, and behavioral functioning; and functional abilities; and impact of these on decision making.
- Testing tools administered, relevant test scores, limitations of any tests, and validity statement.
- Description of person's expressed values and preferences related to decision in question and related issues.
- Itemization of information and/or records that were accessed or reviewed (collateral data sources, third-party informants, medical records, relevant documents), and information that was sought but not available, with contact information of significant collaterals.

### Impressions / Discussion

- Analysis of decision-making abilities, including retained capacities and supports that are in place.
- Relate data to specific steps of decision making process, including risk assessment analysis.
- Explain path of analysis to conclusions, along with potential alternative arguments and relative evidence.
- Describe risk conditions and how any risk might be mitigated.

### Findings

- Diagnosis and prognosis, including whether the underlying condition is static or dynamic.
- Statement of clinical judgment of capacity (note, not a legal determination of capacity).
- Any other determinations, e.g. vulnerable adult status, evidence of undue influence, etc.
- State that your findings are based on your assessment and information available at the time of the visit.

### Recommendations

- Recommendations as to how their capacity can be maximized (e.g., by identifying strategies to reduce risk and/or what supports could be put in place to enhance capacity).
- Specific protective measures, follow-up items, and urgency of each.
- Any need for a follow-up evaluation and if so, when.

### Signing/format

- Format the report with identifying information (client name, DOB) and page numbers in the header/footer.
- Report should be signed with your full name and licensure/credentials, with the date and time signed.
- Save your signed document as a PDF so the format is protected when shared (securely) with others.