Documentation Guidance for Decisional 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. Below are recommendations for information to include in your documentation:

Context

- Date, time, duration, location of visit, relevant demographics of person assessed, 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 consent/notification process and the person's understanding of it.
- 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 as appropriate.
- Assessment of the person's cognitive (including executive functioning), emotional, and behavioral functioning and functional abilities (not just diagnoses), values, and how these impact decision-making.
- Testing tools administered, relevant test scores, limitations of any tests that were employed, all using language and concepts that the reader can understand.
- Information that were accessed/reviewed (collateral data sources, third-party informants, relevant records), and information that was sought but not available – with contact information of significant collaterals.

Impressions / Discussion

- Describe risk conditions and how any risk might be mitigated.
- 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.

Findings

- Diagnosis and prognosis, including whether the underlying condition is static or dynamic.
- Statement of clinical judgment of capacity (not a legal determination of capacity).
- Any other determinations, e.g. vulnerable adult status, evidence of undue influence, etc.

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 follow-up items and urgency.
- Any need for a follow-up evaluation and if so, when.

Signing/format

- Be sure the report is formatted with identifying information and page numbers in the header or footer of the document.
- 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.

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