CAPACITY ASSESSMENT INSTRUMENT FOR INFORMED CONSENT FOR PSYCHOTROPIC MEDICATIONS

NAME: _____

DATE: _____

INSTITUTION: _____

DATE OF BIRTH: _____

PLEASE RECORD THE PATIENT'S RESPONSES TO THE FOLLOWING QUESTIONS:

1. What is your name?

2. What is the date?

3. What is the name of this place?

4. Do you know where this place is located?

5. Why are you here?

6. What is your diagnosis? Do you have a mental illness?

7. Who is your doctor?

8. Do you take any medications? List:

9. What has your doctor told you about the psychotropic medication he is prescribing?

   a. Do they think it will help you? In what way?

   b. Do you think it will help? In what way?

   c. What are the side effects?

   d. Do you have to take medications for the side effects?

   e. Has the doctor discussed tardive dyskinesia with you?

10. Do you have any objections regarding the prescribed medications? If yes, what are they?

11. Does the medication interact with your other medicines? With street drugs or alcohol?

12. What other medications or treatment options have you been offered?

13. Has your doctor told you that the judge might authorize the administration of medication over your objections?

15. How do you feel about that?

16. Have you ever heard of "informed consent"?

17. What does that mean to you?

_____ The patient appears to have the capacity to give informed consent.

_____ The patient does not appear to have the capacity to give informed consent.

_____ _____

Signature Title

_____ _____

Name (Please Print) Date

47.30.839(d)(1); 47.30.915(b)