



## 5. Capacity for involvement in making this plan

Does the person have capacity to participate in making recommendations on this plan?  **Yes**  **No**  
Document the full capacity assessment in the clinical record.

If no, in what way does this person lack capacity?

If the person lacks capacity a ReSPECT conversation must take place with the family and/or legal welfare proxy.

## 6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that (select A,B or C, OR complete section D below):

- A** This person has the mental capacity to participate in making these recommendations. They have been fully involved in this plan.
- B** This person does not have the mental capacity, even with support, to participate in making these recommendations. Their past and present views, where ascertainable, have been taken into account. The plan has been made, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.
- C** This person is less than 18 years old (16 in Scotland) and (please select 1 or 2, and also 3 as applicable or explain in section D below):
- 1** They have sufficient maturity and understanding to participate in making this plan
- 2** They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
- 3** Those holding parental responsibility have been fully involved in discussing and making this plan.
- D** If no other option has been selected, valid reasons must be stated here: (Document full explanation in the clinical record.)

## 7. Clinicians' signatures

Grade/speciality	Clinician name	GMC/ NMC/ HCPC no.	Signature	Date & time
Senior responsible clinician:				

## 8. Emergency contacts and those involved in discussing this plan

Name (tick if involved in planning)	Role and relationship	Emergency contact no.	Signature
Primary emergency contact: <input type="checkbox"/>			optional
<input type="checkbox"/>			optional
<input type="checkbox"/>			optional
<input type="checkbox"/>			optional
<input type="checkbox"/>			optional

## 9. Form review

Review date	Signature

If this page is on a separate sheet from the first page: Name:

DoB:

ID number:

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