Alberta Health Services

Regional Capacity Assessment Team (RCAT) Referral – Community

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X)		

Regional Capacity Assessment Team (RCAT) - Bridgeland Site - 1070 McDougall Rd. NE
Calgary AB, T2E 7Z2 - Telephone 955-1555 - Fax 955-1564

Form Completed By *(please print)*		
Contact Phone Number	Contact Fax Number	Date *(yyyy-Mon-dd)*

The referring Hospitalist or Attending Physician MUST sign the form prior to submitting the referral in order for us to proceed.

I, the below signed physician, according to Alberta Legislation;
a) agree that the capacity assessment proceed in the event that the patient is unable to provide informed consent but is willing to assent to the capacity assessment, and
b) have conducted a medical evaluation of the adult on the date listed below, and have determined that the adult is not currently suffering from a reversible temporary medical condition that appears likely to have a significant impact on his or her capacity to make a decision about a personal matter or financial matters. I understand that medical conditions in this context could include psychiatric conditions.

Signature of the Hospitalist/Attending Physician	
Phone Number	Print Name

Please Confirm The Medical Evaluation Date *(yyyy-Mon-dd)* _____
Must be within the 3 Month period immediately preceding the Capacity Assessment

Client's Name	Date of Birth *(yyyy-Mon-dd)*
PHN	Gender ☐ Male ☐ Female
Address	
Postal Code	Phone Number
Family/Personal Contact	
Relationship to Client	Phone Number

Marital Status ☐ Married/Common-law ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

Current Living Arrangements *(check all that apply)*
☐ Alone ☐ With spouse ☐ Seniors/Supported housing _____
☐ With family ☐ LTC Facility _____ ☐ No Fixed Address _____

Current Community Supports
☐ Community Mental Health Contact _____ Number _____
☐ Home Care Contact _____ Number _____
☐ Other _____ Contact _____ Number _____

Does patient require a translator ☐ No ☐ Yes If yes what language?

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Primary Medical Diagnoses	
1	2
3	4

Indicate areas of Personal Capacity in question <u>based on documented evidence</u>

☐ Health care
☐ Accommodation
☐ Choice of associates
☐ Participation in social activities
☐ Legal (non-financial)

Describe why their Personal Capacity is being called into question now?

Indicate areas of Financial Capacity in question <u>based on documented evidence</u>

☐ Financial Management ☐ Risk of Exploitation ☐ Ability to write EPOA

Describe why their Financial Capacity is being called into question now?

Have you referred your client to other agencies in order to obtain this assessment?

☐ No ☐ Yes If Yes where _____

Has the patient been determined to lack capacity in the past? *(attach supporting documents)*

☐ No ☐ Yes If Yes when _____

What is the referring physician's determination regarding this patient's capacity?

☐ Lacks capacity ☐ Has Capacity ☐ Unsure about determination

Is there an existing Personal Directive?	**Is there an existing Enduring Power of Attorney?**
☐ Yes ☐ No	☐ Yes ☐ No

Most Recent Cognitive Assessment Score *(If available)*	Date *(yyyy-Mon-dd)*
Most Recent MOCA Score *(If available)*	Date *(yyyy-Mon-dd)*

Is the patient aware of the referral to RCAT? *(Patient should be informed prior to making referral to RCAT)*

☐ Yes ☐ No

Please attach the following documents:

☐ List of current medications
☐ Discipline specific assessments, consults, & reports
☐ Neuroimaging reports
☐ Most recent laboratory results
☐ Recent progress notes/contact notes
☐ Hospital discharge summaries