Part 1

"capacity" means the ability to understand the information that is relevant to the making of a personal decision and the ability to appreciate the reasonably foreseeable consequences of the decision (s1 (b) of the Personal Directives Act).

I, ________________________________, am designated in the personal directive made by the maker, ________________________________, as the person who is to determine his/her capacity.

Before conducting an assessment of the capacity of the maker, I met with the maker and explained the purpose and nature of the assessment, the maker's right to refuse to be assessed and the significance and effect of a finding that the maker lacks capacity to make personal decisions.

The reason(s) I assessed the maker's capacity are as follows: ________________________________

I identified that an assessment of the maker's ability to make personal decisions was warranted with respect to the following personal matters:

I have determined and declare that ________________________________ lacks the capacity to make decisions about the following personal matter(s) of a non-financial nature (check any or all that apply):

- health care
- accommodation
- with whom to live and associate
- participation in social activities
- participation in educational activities
- participation in employment activities
- legal matters
- other ________________________________
The reasons for my determination are as follows:

1. The level of consciousness of the maker at the time of my determination was (check one):
   - [ ] alert
   - [ ] fluctuating
   - [ ] non-responsive

2. It is my understanding that all temporary medical conditions that may affect the maker's capacity have been ruled out:  [ ] Yes

3. In my opinion, the maker:
   - [ ] Is unable to understand the information that is needed to make a decision about the above-specified personal matter(s) and is unable to understand the options presented.  [ ] Yes  [ ] No
     My reason(s) for this opinion are as follows:
     

   - [ ] Is unable to retain the information relevant to making a decision about the above-specified personal matter(s).  [ ] Yes  [ ] No
     My reason(s) for this opinion are as follows:

   - [ ] Is unable to identify and appreciate the consequences of making or not making a decision about the above-specified personal matter(s).  [ ] Yes  [ ] No
     My reason(s) for this opinion are as follows:

   - [ ] Is unable to communicate his/her decision about the above-specified personal matter(s).  [ ] Yes  [ ] No
     My reason(s) for this opinion are as follows:

I recommend that this declaration be reviewed on _________________.  (Optional)

Dated at ____________________________ in the Province of Alberta this ______ day of

__________________ (month)  ____________________ (year).

____________________ Printed name of person completing Part 1  ____________________ Signature of person completing Part 1
Part 2

(To be completed by the physician or psychologist consulted by the person who completed Part 1.)

I, ____________________________, am a member in good standing of the
__________________________________________________________.

(College of Physicians and Surgeons of the Province of Alberta / College of Alberta Psychologists)

Before conducting an assessment of the capacity of the maker, ____________________________,
I met with the maker and explained the purpose and nature of the assessment, the maker's right to
refuse to be assessed and the significance and effect of a finding that the maker lacks capacity to
make personal decisions.

I have interviewed the maker and consulted with ____________________________.

(name of person who completed Part 1)

The reason(s) I assessed the maker's capacity are as follows:

________________________________________________________________________________________

________________________________________________________________________________________

I am of the opinion that ____________________________ lacks the capacity to make decisions
about the following personal matter(s) of a non-financial nature (check any or all that apply):

☐ health care
☐ accommodation
☐ with whom to live and associate
☐ participation in social activities
☐ participation in educational activities
☐ participation in employment activities
☐ legal matters
☐ other ____________________________

The reasons for my determination are as follows:

1. The level of consciousness of the maker at the time of my determination was (check one):

☐ alert
☐ fluctuating
☐ non-responsive

2. Based on the medical evaluation done by ____________________________ on

______________________________ (day/month/year)

, all temporary medical conditions that may affect the capacity of the maker
have been ruled out: ☐ Yes
3. In my opinion, the maker:
   - Is unable to understand the information that is needed to make a decision about the above-specified personal matter(s) and is unable to understand the options presented. □ Yes □ No
     My reason(s) for this opinion are as follows:
     ____________________________
     ____________________________
     ____________________________
   - Is unable to retain the information that is relevant to making a decision about the above-specified personal matter(s). □ Yes □ No
     My reason(s) for this opinion are as follows:
     ____________________________
     ____________________________
     ____________________________
   - Is unable to identify and appreciate the consequences of making or not making a decision about the above-specified personal matter(s). □ Yes □ No
     My reason(s) for this opinion are as follows:
     ____________________________
     ____________________________
     ____________________________
   - Is unable to communicate his/her decision about the above-specified personal matter(s).
     □ Yes □ No
     My reason(s) for this opinion are as follows:
     ____________________________
     ____________________________
     ____________________________

4. I have attached a more detailed capacity assessment or report. (Optional) □ Yes □ No

I recommend that this declaration be reviewed on __________________. (Optional)

Dated at ___________________________ in the Province of Alberta this ______ day of
_________  
_________  (location) (month) (year) .

Printed name of physician/psychologist completing Part 2

Signature of physician/psychologist completing Part 2