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Notice of Determination of Patient Incapacity Pursuant to **Massachusetts Health Care Proxy** ACT M.G.L.C.201D

Notice is hereby given that I, _____, on the date cited below, have determined that _____, lacks the capacity to make or communicate health care decisions. This determination has been made according to accepted standards of medical judgement and pursuant to M.G.L.C.201D, the Massachusetts Health Care Proxy Act. The cause, nature, extent and probable duration of the patient's incapacity are described below:

Cause: _____
_____

Nature: _____
_____

Extent: _____
_____

Duration:_____
_____

Physician Signature: _____ Date: _____

Directions: Complete this form for patients who have executed a Massachusetts Health Care Proxy and who subsequently lose the capacity to make or communicate health care decisions. A copy of this form must be entered into the patient's medical record along with the Health Care Proxy.

Deactivation date: _____ Physician Signature: _____