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| Case ID Number: | | | | | | | | | | | |
| **DEPRIVATION OF LIBERTY SAFEGUARDS FORM 1**  **REQUEST FOR STANDARD AUTHORISATION AND URGENT AUTHORISATION**  ***These forms have been adapted for use by the Eastern Region from the ADASS/DoH DoLS Forms***  **PLEASE NOTE BEFORE COMPLETING THIS FORM**  **In 1.13 of the DoLS’ Code of Practice:-**  **“Depriving someone who lacks the capacity to consent to the arrangements made for their care or treatment of their liberty is a serious matter and the decision to do so should not be taken lightly.”**  **As such, please ensure that the information that you provide for this request in Part A must be person centred with details as to how the restrictions of the person’s care regime amount to a deprivation of the person’s liberty . Please also provide documentary evidence that the person is unable to give valid consent to their placement in the care home or hospital as the DoLS only applies to those assessed as lacking capacity in this regard.** | | | | | | | | | | | |
| Request a **Standard Authorisation** only **(*you DO NOT need to complete Part D)*** | | | | | | | | | | |  |
| Grant an **Urgent Authorisation** ***(please ALSO complete Part D)*** | | | | | | | | | | |  |
| Full name of person being deprived of liberty | |  | | | | | | | Sex | | |
| Date of Birth *(or estimated age if unknown)* | |  | | | | | | | Est. Age | | |
| Relevant Psychiatric / Medical History with references to physical disability, frailty or sensory impairment (visual and / or hearing) if applicable: | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Communication  Requirements | Please state preferred first language or whether interpreter or BSL signer is needed: | | | | | | | | | | |
|  | | | | | | | | | | |
| Name and address of the care home or hospital requesting this authorisation | | |  | | | | | | | | |
| Telephone Number | |  | | | | | | | | | |
| Person to contact at the care home or hospital, (including ward details if appropriate) | | Name | | |  | | | | | | |
| Telephone | | |  | | | | | | |
| Email | | |  | | | | | | |
| Ward (if appropriate) | | |  | | | | | | |
| The relevant person’s address prior to admission or placement | |  | | | | | | | | | |
| Is the relevant person waiting to be placed in the care home? | | (If the answer is yes, you can only request a Standard Authorisation and therefore you DO NOT need to complete Part D) | | | | | | | | | |
| YES | |  | | | NO | | |  | |
| Name of the Supervisory Body where this form is being sent | |  | | | | | | | | | |
| How the care is funded | | Local Authority  Please Specify | | | |  | | | | | |
| CCG (Please specify) | | | |  | | | | | |
| Local Authority and CCG (jointly funded) | | | |  | | | | | |
| Self-funded by person or family | | | |  | | Funded through insurance or other | | |  |

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| **PART A - REQUEST FOR STANDARD AUTHORISATION** | |
| **THE DATE FROM WHICH THE STANDARD AUTHORISATION IS REQUIRED:**  *If standard only – within 21 days*  *If an urgent authorisation is also included– within 7 or 14 days* |  |
| **PURPOSE OF THE STANDARD AUTHORISATION**   * *Please describe the care and / or treatment this person is receiving day-to-day and attach a relevant care plan.* * *Please give as much detail as possible about the type of care the person needs, including personal care, mobility, medication, support with behavioural issues, how much choices the person has and any medical treatment they receive.* * *Please submit documentary evidence that the person lacks capacity to give valid consent to the placement in this care home or admission to this hospital for the purpose of being given the proposed care and or treatment because of an impairment of, or a disturbance in the functioning of the mind or brain.* | |
|  | |
| * *Explain why within the care / treatment regime that you are providing, the person is not free to leave and why they are under continuous or complete supervision and control.* * *Describe the restrictions you have put in place which are necessary to ensure the person receives care and treatment.* * *Describe why less restrictive options are not possible including risks of harm to the person.* * *Indicate the frequency of the restrictions you have to put in place.* | |
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| **PART B**  **INFORMATION ABOUT INTERESTED PERSONS AND OTHERS TO CONSULT** | | |
| Family member or friend | Name and relationship to relevant person |  |
| Address |  |
| Telephone |  |
| Anyone named by the person as someone to be consulted about their welfare | Name |  |
| Address |  |
| Telephone |  |
| Anyone engaged in caring for the person or interested in their welfare | Name |  |
| Address |  |
| Telephone |  |
| Any donee of a Lasting Power of Attorney for Health and Welfare granted by the person | Name |  |
| Address |  |
| Telephone |  |
| Any Deputy for Health and Welfare appointed for the person by the Court of Protection | Name |  |
| Address |  |
| Telephone |  |
| Any IMCA instructed in accordance with sections 37 to 39D of the Mental Capacity Act 2005 | Name |  |
| Address |  |
| Telephone |  |

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| **WHETHER IT IS NECESSARY FOR AN INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA) TO BE INSTRUCTED** *Place a cross in EITHER box below* | | | | | | | | |
| Apart from professionals and other people who are paid to provide care or treatment, this person has no-one whom it is appropriate to consult about what is in their best interests | | | | | | | |  |
| There is someone whom it is appropriate to consult about what is in the person’s best interests who is neither a professional nor is being paid to provide care or treatment | | | | | | | |  |
| **WHETHER THERE IS A VALID AND APPLICABLE ADVANCE DECISION**  *Place a cross in one box below* | | | | | | | | |
| The person has made an Advance Decision that may be valid and applicable to some or all of the treatment | | | | | | | |  |
| The Managing Authority is not aware that the person has made an Advance Decision that may be valid and applicable to some or all of the treatment | | | | | | | |  |
| The proposed deprivation of liberty **is not** for the purpose of giving treatment | | | | | | | |  |
| **THE PERSON IS SUBJECT TO SOME ELEMENT OF THE MENTAL HEALTH ACT (1983)** | | | | | | | | |
| Yes |  | | No |  | *If* ***Yes*** *please describe further* | | | |
|  | | | | | | | | |
| **OTHER RELEVANT INFORMATION** | | | | | | | | |
| Names and contact numbers of regular visitors not detailed elsewhere on this form: | | | | | | | | |
| Any other relevant information including safeguarding issues: | | | | | | | | |
| **PLEASE NOW SIGN AND DATE THIS FORM** | | | | | | | | |
| Signature | |  | | | | Print Name |  | |
| Position | |  | | | | | | |
| Date | |  | | | | Time |  | |
| **I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A DoLS AUTHORISATION** *(Please sign and date to confirm)* | | | | | |  | | |

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| **PART C**  **RACIAL, ETHNIC OR NATIONAL ORIGIN**  *Place a cross in one box only* | | | | | | | | |
| White | |  | | | Mixed / Multiple Ethnic groups | |  | |
| Asian / Asian British | |  | | | Black / Black British | |  | |
| Not Stated | |  | | | Undeclared / Not Known | |  | |
| Other Ethnic Origin *(please state)* | | |  | | | | | |
| **THE PERSON’S SEXUAL ORIENTATION**  *Place a cross in one box only* | | | | | | | | |
| Heterosexual |  | | | | Homosexual | |  | |
| Bisexual |  | | | | Undeclared | |  | |
| Not Known |  | | | |  | | | |
| **OTHER DISABILITY**  *While the person must have a mental disorder as defined under the Mental Health Act 1983, there may be another disability that is primarily associated with the person. This is based on the primary client types used in the Adult Social Care returns.*    *To monitor the use of DoLS, the HSCIC requests information on other disabilities associated with the individual concerned. The presence of “other disability” may be unrelated to an assessment of mental disorder or lack of capacity. Place a cross in one box only* | | | | | | | | |
| Physical Disability: Hearing Impairment | | | |  | | Physical Disability: Visual Impairment | |  |
| Physical Disability: Dual Sensory Loss | | | |  | | Physical Disability: Other | |  |
| Mental Health needs: Dementia | | | |  | | Mental Health needs: Other | |  |
| Learning Disability | | | |  | | Other Disability (none of the above) | |  |
| No Disability | | | |  | |  | |  |
| **RELIGION OR BELIEF**  *Place a cross in one box only* | | | | | | | | |
| None | | | |  | | Not stated | |  |
| Buddhist | | | |  | | Hindu | |  |
| Jewish | | | |  | | Muslim | |  |
| Sikh | | | |  | | Any other religion | |  |
| Christian  (includes Church of Wales, Catholic, Protestant and all other Christian denominations) | | | | | | | |  |

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| **PART D**  **ONLY COMPLETE THIS SECTION IF YOU NEED TO GRANT AN URGENT AUTHORISATION BECAUSE IT APPEARS TO YOU THAT THE DEPRIVATION OF LIBERTY IS ALREADY OCCURING AND ALL THE FOLLOWING CONDITIONS ARE MET** | | | | |
| **URGENT AUTHORISATION**  ***Place a cross in EACH box to confirm that the person appears to meet the particular condition*** | | | | |
| The person is aged 18 or over | | | |  |
| The person is suffering from a mental disorder | | | |  |
| The person is being accommodated here for the purpose of being given care or treatment. **Please describe further in Part A** | | | |  |
| The person lacks capacity to make their own decision about whether to be accommodated here for care or treatment  **Please submit documentary evidence** | | | |  |
| The person has not, as far as the Managing Authority is aware, made a valid Advance Decision that prevents them from being given any proposed treatment | | | |  |
| Accommodating the person here, and giving them the proposed care or treatment, does not, as far as the Managing Authority is aware, conflict with a valid decision made by a donee of a Lasting Power of Attorney or Deputy for Health and Welfare appointed by the Court of Protection under the Mental Capacity Act 2005 | | | |  |
| It is in the person’s best interests to be accommodated here to receive care or treatment, even though they will be deprived of liberty | | | |  |
| Depriving the person of liberty is necessary to prevent harm to them, and a proportionate response to the harm they are likely to suffer otherwise | | | |  |
| The person concerned is not, as far as the Managing Authority is aware, subject to an application or order under the Mental Health Act 1983 or, if they are, that order or application does not prevent an Urgent Authorisation being given | | | |  |
| The need for the person to be deprived of liberty here is so urgent that it is appropriate for that deprivation to begin immediately | | | |  |
| **AN URGENT AUTHORISATION IS NOW GRANTED**  This Urgent Authorisation comes into force immediately.  It is to be in force for a period of: days  ***The maximum period allowed is seven days.***  This Urgent Authorisation will expire at the end of the day on: | | | | |
| Signed |  | Print name |  | |
| Position |  | | | |
| Date |  | Time |  | |

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| **REQUEST FOR AN EXTENSION TO THE URGENT AUTHORISATION**  *If Supervisory Body is unable to complete the process to authorise the deprivation of liberty* | | | | | | | |
| A Standard Authorisation has been requested for this person and an Urgent Authorisation is in force.  The Managing Authority now requests that the duration of this Urgent Authorisation is extended for a further period of DAYS (***up to a maximum of 7 days***)  It is essential for the existing deprivation of liberty to continue until the request for a Standard Authorisation is completed because the person needs to continue to be deprived and exceptional reasons are as follows (*please record your reasons):*  ***Please now sign, date and send to the SUPERVISORY BODY for authorisation*** | | | | | | | |
| Signature |  | | | Date |  | | |
| **RECORD THAT THE DURATION OF THIS URGENT AUTHORISATION HAS BEEN EXTENDED**  This part of the form must be completed by the **SUPERVISORY BODY** if the duration of the Urgent Authorisation is extended. **The Managing Authority does not complete this part of the form.**  The duration of this Urgent Authorisation has been extended by the Supervisory Body.  It is now in force for a **further** days  **Important note: The period specified must not exceed seven days.**  This Urgent Authorisation will now expire at the end of the day on: | | | | | | | |
| **SIGNED**  (on behalf of the Supervisory Body) | | Signature |  | | | | |
| Print Name |  | | | | |
| Position |  | | | | |
| Date |  | | | Time |  |