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| **DEPRIVATION OF LIBERTY SAFEGUARDS FORM 1****MANAGING AUTHORITY’S REQUEST FOR STANDARD AUTHORISATION and MANAGING AUTHORITY’S URGENT AUTHORISATION**  |
| Full name of person being deprived of liberty |  | Sex |
| Date of Birth *(or estimated age if unknown)* |  |
| **Person to contact and details of care home or hospital (Managing Authority)** |
| Name |  |
| Address (including ward if appropriate) |  |
| Telephone |  |
| Email |  |
| Usual address of the person liable to be deprived of liberty, (if different to above) |  |
| Telephone Number |  |
| Name and address of the Supervisory Body where this form is being sent |  |
| Details of Care Co-ordinator/Care Manager |  |
| Communication Needs and any relevant medical history |  |

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| **REQUEST FOR STANDARD AUTHORISATION – TO BE COMPLETED IN ALL CASES** |
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| **THE NATURE OF THE PROPOSED DEPRIVATION OF LIBERTY*** Explain why the person is or will not be free to leave and why they are under continuous supervision and continuous control (the acid test).
* A RELEVANT CARE PLAN SHOULD BE ATTACHED which should describe the restrictions (including their frequency) you have put/propose to put in place which are necessary to ensure the person receives care and treatment. (It will be helpful if you can describe why less restrictive options are not possible including risks of harm to the person.) it should also included details of personal care, mobility, medication, support with behavioural issues, types of choice the person had and any medical treatment the person is receiving.
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| **INFORMATION ABOUT INTERESTED PERSONS AND OTHERS TO CONSULT- including relationship to person being deprived of their liberty:** * Family member or friend;
* Anyone named by the person as someone to be consulted about their welfare;
* Anyone engaged in caring for the person or interested in their welfare;
* Any donee of a Lasting Power of Attorney for Health and Welfare granted by the person;
* Any Deputy for Health and Welfare appointed for the person by the Court of Protection;
* Any IMCA instructed in accordance with sections 37 to 39D of the Mental Capacity Act 2005 *(****PLEASE EXPAND LIST IF NEEDED)***
 |
| Name |  |
| Address |  |
| Telephone |  |
| Name  |  |
| Address |  |
| Telephone |  |
| **IS IT NECESSARY FOR AN INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA) TO BE INSTRUCTED?** Place a cross in EITHER box below |
| **YES:** 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. |  |
| **NO**: 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. |  |
| **IS THERE A VALID AND APPLICABLE ADVANCE DECISION?**Place a cross in EITHER box below |
| **YES**: The person has made an Advance Decision that may be valid and applicable to some or all of the treatment. |  |
| **NO**: 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.‘’’’ |  |
| **IS THE PERSON SUBJECT TO SOME ELEMENT OF THE MENTAL HEALTH ACT 1983?** |
| **Yes** |  | **No** |  | If **Yes** please describe further |
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| **RELEVANT PERSON’S WISHES AND FEELINGS**Is the person objecting to care and treatment, if so, what are they objecting to? What are the relevant person’s wishes, feelings, beliefs and values (present and past) so far as they can be ascertained and have they/have not been met? **Note**:(If a deprivation of liberty has been identified for a mental health patient accommodated for the purpose of treatment for a mental disorder and they are objecting to care and treatment for their mental disorder only the Mental Health Act 1983 can be used to deprive the person of their liberty). |
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| **I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A DoLS AUTHORISATION**  |  |
| **PLEASE NOW SIGN AND DATE THIS FORM (to be signed by the Managing Authority*)*** |
| Signature  |  | Print Name |  |
| Position  |  |
| Date |  | Time |  |
| **ONLY COMPLETE THIS SECTION IF YOU ARE GRANTING AN URGENT AUTHORISATION**  |
| **MANAGING AUTHORITY’S 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.  |  |
| The person lacks capacity to make their own decision about whether to be accommodated here for care or treatment |  |
| 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 MADE** This Urgent Authorisation comes into force immediately.It is to be in force from **MM:HH** on **DD:MM:YYYY** a period of **XX** Days ***The maximum period allowed is seven days.***This Urgent Authorisation will expire at **MM:HH** on **DD:MM:YYYY****PLEASE NOW SIGN AND DATE THIS FORM *(to be signed on behalf of the Managing Authority)*** |
| Signed |  | Print name |  |
| Position |  |
| Date |  | Time |  |

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| **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) |  |