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| **DEPRIVATION OF LIBERTY SAFEGUARDS FORM 4****MENTAL HEALTH and ELIGIBILITY ASSESSMENTS** |
| This combined form contains 2 separate assessments. Should the requirements of any assessment not be met, the remaining assessments need not be completed unless they have been specifically commissioned by the Supervisory Body. |
| **Please indicate which assessments have been completed** |
| Mental Health |  | Eligibility |  |
| This form is being completed in relation to a request for a standard authorisation. |  |
| This form is being completed in relation to a review of an existing Standard Authorisation under Part 8 of Schedule A1 to the Mental Capacity Act 2005. |  |
| Full name of the person being deprived of their liberty |  |
| Date of birth*(or estimated age if unknown)* |  |
| **Person to contact and details of the 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 Bosy where this form is being sent |  |

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| **MENTAL HEALTH ASSESSMENT** |
| In carrying out this assessment, I have taken into account any information given to me, and any submissions made by any of the following:1. The relevant person’s representative
2. Any IMCA instructed for the person in relation to their deprivation of liberty
3. I have consulted the Best Interests Assessor for any relevant information about possible objections to treatment, including whether any donee or Deputy has made a valid decision to consent to any mental health treatment.
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| **Place a cross in EITHER box below (to be completed by a S.12 doctor under the Mental Health Act 1983, or a doctor who the Supervisory Body consider to have relevant experience in the diagnosis or treatment of a medical disorder)** |
| In my opinion the person **IS NOT** suffering from a mental disorder within the meaning of the Mental Health Act 1983 (disregarding any exclusion for persons with learning disability).Provide a rationale for your opinion, including details of their symptoms, diagnosis and behaviour |  |
|  |
| In my opinion the person **IS** suffering from a mental disorder within the meaning of the Mental Health Act 1983 (disregarding any exclusion for persons with learning disability).Provide a rationale for your opinion, including details of their symptoms, diagnosis and behaviour |  |
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| In my opinion, the person’s mental health and wellbeing is likely to be affected by being deprived of liberty in the following ways: |

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| **ELIGIBILITY ASSESSMENT** |
| **Answer ALL of the following questions Yes or No, by placing a cross in the relevant box.** |
| The person is detained under section 2, 3, 4, 35-38, 44, 45A, 47, 48 or 51 of the Mental Health Act 1983). | Yes |  |
| No |  |
| The person is subject to s17 leave or conditional discharge, or Community Treatment Order, or Guardianship, and a Standard Authorisation would be incompatible with a Mental Health Act requirement (i.e. as to residence) | Yes |  |
| No |  |
| If you have answered “Yes” to either of the above, the person is ineligible for DoLS.Please give reasons/explanation for your answer: |
| **Hospital Cases Only**  |
| The purpose of detention is to receive medical treatment for mental disorder | Yes |  |
| No |  |
| In my opinion this person could be detained under the Mental Health Act (on the assumption that the person cannot be assessed and treated under the Mental Capacity Act 2005)Please explain further: | Yes |  |
| No |  |
| **If the answer to both of the above statements is YES please consider the next two statements****If either of the below are ticked the person is ineligible for DoLS** |
| The person objects, or would object if able to do so, to some or all of the medical treatment for a mental disorderPlease explain further**:** | Yes |  |
| Is the deprivation of liberty safeguards the least restrictive way of best achieving the proposed care and treatment?Describe the least restrictive way of best achieving the proposed care and treatment: | No |  |
| **CONFIRMATION OF REQUEST FOR MENTAL HEALTH ACT ASSESSMENT** |
| Date and Time of request for Mental Health Act Assessment |  |
| Name of Person to which the request was made |  |
| **PLEASE NOW SIGN AND DATE THIS FORM (*signed on behalf of the Supervisory Body)*** |
| Signed |  | Date |  |
| Print Name |  | Time |  |
|  ***In order to safeguard their rights please request that the person is assessed under the Mental Health Act and confirm this below:*** |