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| **PART A** | | | ***This form is to be completed electronically. The boxes will expand as you type.*** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Case ID Number**: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DEPRIVATION OF LIBERTY SAFEGUARDS FORM 1**  **REQUEST FOR STANDARD AUTHORISATION AND URGENT AUTHORISATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Request a **Standard Authorisation** only**( i.e. If the person is not already a resident but is planned for admission *you DO NOT need to complete pages 6 or 7)*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Grant an **Urgent Authorisation** ***(i.e. The person is already a resident please ALSO complete pages 6 and 7)*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Full name of person being deprived of liberty | | | | | | | | | | | | | |  | | | | | | | | | Sex | | | | | | | | |
| Date of Birth *(or estimated age if unknown)* | | | | | | | | | | | | | |  | | | | | | | | | Est. Age | | | | | | | | |
| **Guidance note: Mental Disorder**  A mental disorder or any disability of the mind, apart from the dependency on alcohol or drugs. This includes all learning disabilities. The distinction in the Mental Health Act 1983 between learning disabilities depending on whether or not they are associated with abnormally aggressive or seriously irresponsible behaviour is not relevant.  If there is no diagnosed mental disorder resulting in cognitive impairment, please provide evidence regarding the cognitive impairment (why there is presumption of lack of capacity?) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Relevant Medical History (including diagnosis of mental disorder if known) **Please detail**: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sensory Loss | | | | | |  | | | | | | | Communication Requirements | | | | | |  | | | | | | | | | | | | |
| Name and address of the care home or hospital requesting this authorisation | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| Admission date: | | | | | | | | | | | | | POST CODE: | | | | | | | | | | | | | | | | | | |
| Telephone Number | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Person to contact at the care home or hospital, (including ward details if appropriate) | | | | | | | | | | | Name | | | | | |  | | | | | | | | | | | | | | |
| Telephone | | | | | |  | | | | | | | | | | | | | | |
| Email | | | | | |  | | | | | | | | | | | | | | |
| Ward (if appropriate) | | | | | |  | | | | | | | | | | | | | | |
| Usual address of the person, (if different to above) | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Telephone Number | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Name of the Supervisory Body where this form is being sent | | | | | | | | | | | | **Stockport Supervisory Body** | | | | | | | | | | | | | | | | | | | |
| How the care is funded | | | | | | | | | | | | Local Authority (*please specify)* | | | | | |  | | | | | | | | | | | | | |
| NHS | | | | | |  | | | Local Authority and NHS (jointly funded) | | | | | | |  | | | |
| Self-funded by person | | | | | |  | | | Funded through insurance or other | | | | | | |  | | | |
| **PART B** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **REQUEST FOR STANDARD AUTHORISATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **THE DATE FROM WHICH THE STANDARD AUTHORISATION IS REQUIRED:**  *If standard only – within 28 days*  *If an urgent authorisation is also attached – within 7 days* | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| **PURPOSE OF THE STANDARD AUTHORISATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Please ensure this section of the form details the following information****:* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please explain why the person is in hospital/care home, providing as much detail as possible about the care and/or treatment the person is receiving, eg information about personal care, mobility, medication, support with behavioural issues.  **PLEASE ATTACH A RELEVANT CARE PLAN IF AVAILABLE.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ANSWER:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is there evidence that the person lacks the mental capacity to consent to receiving care and treatment in this hospital/care home? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ANSWER:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is the person objecting, either verbally or physically, e.g. asking to leave, resistant to care, packing their belongings, attempting to leave?  *(Context may be important – could you elaborate about the possible reasons for their behaviour – could this be due to confusion (e.g. P is stating they need to go home to pick up their children, but P is 98 years and their children are adults).* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ANSWER:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **\*\*Please note:** The Deprivation of Liberty Authorisation does not itself authorise the care or treatment concerned, the giving of which is subject to the wider provisions of the Mental Capacity Act 2005\*\* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ADDITIONAL INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Explain why the person is or will not be free to leave and why they are under continuous or complete supervision and control. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ANSWER:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is there a locked door policy? *(Cross one Box)* | | | | | | | | | | | | | | | | | | | | | Yes | | |  | No | | |  | | | |
| How often is the person monitored and checked on by staff during the day and/or night? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ANSWER:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is there a motion sensor/bed sensor or door sensor in their bedroom? *(Cross one Box)* | | | | | | | | | | | | | | | | | | | | | Yes | | |  | No | | |  | | | |
| Are there bed rails in place? *(Cross one Box)* | | | | | | | | | | | | | | | | | | | | | Yes | | |  | No | | |  | | | |
| Describe the proposed restrictions or the restrictions you have 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.)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ANSWER:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are there any physical restraints - this includes hands on interventions, seclusion, use of equipment such as hoists? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ANSWER:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medication (including PRN) – Is the person prescribed sedative or anti-psychotic medication? *(Cross one Box)* | | | | | | | | | | | | | | | | | | | | | Yes | | |  | No | | |  | | | |
| Is this medication being used to control behaviour? *(Cross one Box)* | | | | | | | | | | | | | | | | | | | | | Yes | | |  | No | | |  | | | |
| Is medication given covertly? (For example crushed or hidden in food or drink) *(Cross one Box)* | | | | | | | | | | | | | | | | | | | | | Yes | | |  | No | | |  | | | |
| Please detail the frequency of the restrictions in place. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ANSWER:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has the person’s family or representative been informed that a DOLS referral has been made? *(Cross one Box)* | | | | | | | | | | | | | | | | | | | | | Yes | | |  | No | | |  | | | |
| Has the family or the representative expressed an objection to the deprivation/placement? *(Cross one Box)* | | | | | | | | | | | | | | | | | | | | | Yes | | |  | No | | |  | | | |
| Are there any restrictions on contact with family or friends?  *(Cross one Box)* | | | | | | | | | | | | | | | | | | | | | Yes | | |  | No | | |  | | | |
| **INFORMATION ABOUT INTERESTED PERSONS AND OTHERS TO CONSULT** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Family member or friend | | | | | | | | Name | | | | | | FULL NAME PLEASE: | | | | | | | | | | | | | | | | | |
| RELATIONSHIP TO 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, eg Social Worker or CPN | | | | | | | | Name | | | | | |  | | | | | | | | | | | | | | | | | |
| Address | | | | | |  | | | | | | | | | | | | | | | | | |
| Telephone | | | | | |  | | | | | | | | | | | | | | | | | |
| Any donee of a Lasting Power of Attorney granted by the person | | | | | | | | Name | | | | | |  | | | | | | | | | | | | | | | | | |
| Address | | | | | |  | | | | | | | | | | | | | | | | | |
| Telephone | | | | | |  | | | | | | | | | | | | | | | | | |
| Any Personal Welfare Deputy 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 | | | | | |  | | | | | | | | | | | | | | | | | |
| **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 is 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 e.g. application/order/direction, community treatment order, guardianship* | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **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 | | | |  | | | | | | | | | | | | |
| Date | | | |  | | | | | | | | | | | Time | | | |  | | | | | | | | | | | | |

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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)* | | |  | | | | | |
| **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, OR ABOUT TO OCCUR, AND YOU REASONABLY THINK ALL OF 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 ensure purpose and reason are described further on page 2*** | | | | |  |
| 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 Personal Welfare Deputy 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 before the request for the Standard Authorisation is made or has been determined | | | | |  |
| **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, Inclusive of the date this section is signed***  This Urgent Authorisation will expire at the end of the day on: | | | | | |
| Signed |  | | Print name |  | |
| Date |  | | Time |  | |

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| **PART E** |  | | | | | | |
| **REQUEST FOR AN EXTENSION TO THE URGENT AUTHORISATION**  *If Supervisory Body is unable to complete the process to give a Standard Authorisation (which has been requested) before the expiry of the existing Urgent Authorisation* | | | | | | | |
| An Urgent Authorisation is in force and a Standard Authorisation has been requested for this person.  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 |  | | | |
| Date |  | | Time |  |