

Case number

REQUEST FOR A STANDARD AUTHORISATION AND URGENT AUTHORISATION

 Urgent Authorisation has been granted (please complete Part C – Urgent Authorisation)

Part A – BASIC INFORMATION			
A1	DETAILS OF PERSON BEING DEPRIVED OF LIBERTY	Full name	
		Date of Birth (or estimated age if unknown)	
		Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male
		Sensory Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", describe:</i>
		Communication Requirements	
		Relevant Medical History (including diagnosis of mental disorder if known)	
A2	CARE HOME OR HOSPITAL REQUESTING THIS AUTHORISATION	Name	
		Address	
		Telephone	
A3	PERSON TO CONTACT AT THE CARE HOME OR HOSPITAL, (INCLUDING WARD DETAILS IF APPROPRIATE)	Name	
		Telephone	
		Email	
		Ward (if appropriate)	
A4	USUAL ADDRESS OF THE PERSON BEING DEPRIVED OF LIBERTY (IF DIFFERENT TO THE ABOVE IN PART A2)	Address	
		Telephone	

A5	NAME OF THE SUPERVISORY BODY WHERE THIS FORM IS BEING SENT	
A6	HOW THE CARE IS FUNDED	<input type="checkbox"/> Local Authority (<i>please specify</i>) <input type="checkbox"/> NHS <input type="checkbox"/> Local Authority and NHS (jointly funded) <input type="checkbox"/> Self-funded by the person being deprived of liberty <input type="checkbox"/> Funded through insurance or other

Part B – REQUEST FOR STANDARD AUTHORISATION		
B1	THE DATE FROM WHICH THE STANDARD AUTHORISATION IS REQUIRED: <i>If standard only – within 28 days</i> <i>If an urgent authorisation is also attached – within 7 days</i>	
B2	PURPOSE OF THE STANDARD AUTHORISATION	
<p>a. <i>Please describe the care and / or treatment this person is receiving or will receive day-to-day and attach a relevant care plan.</i></p> <p>b. <i>Please give as much detail as possible about the type of care the person needs, including personal care, mobility, medication, support with behavioural issues, types of choice the person has and any medical treatment they receive.</i></p> <p>c. <i>Explain why the person is or will not be free to leave and why they are under continuous or complete supervision and control.</i></p>		

- d. 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.)
- e. Indicate the frequency of the restrictions you have put in place.

B3	THE PERSON IS SUBJECT TO SOME ELEMENT OF THE MENATL HEALTH ACT (1983)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	<i>If Yes please describe further e.g. application/order/direction, community treatment order, guardianship</i>		
B4	WHETHER THERE IS A VALID AND APPLICABLE ADVANCE DECISION		
	<i>Tick one box below</i>		
	<input type="checkbox"/> The person has made an Advance Decision that is valid and applicable to some or all of the treatment		
	<input type="checkbox"/> 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		
B5	WHETHER IT IS NECESSARY FOR AN INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA) TO BE INSTRUCTED		
	<i>Place tick EITHER box below</i>		
	<input type="checkbox"/> 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		
<input type="checkbox"/> 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			

B6	INFORMATION ABOUT INTERESTED PERSONS AND OTHERS TO CONSULT		
ANYONE ENGAGED IN CARING FOR THE PERSON OR INTERESTED IN THEIR WELFARE (E.G. FAMILY MEMBER, FRIEND)	Name		
	Relationship to the person		
	Address		
	Telephone		
ANYONE ENGAGED IN CARING FOR THE PERSON OR INTERESTED IN THEIR WELFARE (E.G. FAMILY MEMBER, FRIEND)	Name		
	Relationship to the person		
	Address		
	Telephone		
ANYONE ENGAGED IN CARING FOR THE PERSON OR INTERESTED IN THEIR WELFARE (E.G. FAMILY MEMBER, FRIEND)	Name		
	Relationship to the person		
	Address		
	Telephone		
ANYONE ENGAGED IN CARING FOR THE PERSON OR INTERESTED IN THEIR WELFARE (E.G. FAMILY MEMBER, FRIEND)	Name		
	Relationship to the person		
	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		

B7	OTHER RELEVANT INFORMATION		
	NAMES AND CONTACT NUMBERS OF REGULAR VISITORS NOT DETAILED ELSEWHERE ON THIS FORM		
	ANY OTHER RELEVANT INFORMATION INCLUDING SAFEGUARDING ISSUES		
B8	RACIAL, ETHNIC OR NATIONAL ORIGIN <i>(Tick one box only)</i>	<input type="checkbox"/> White <input type="checkbox"/> Asian / Asian British <input type="checkbox"/> Black / Black British <input type="checkbox"/> Mixed / Multiple Ethnic groups <input type="checkbox"/> Not Stated <input type="checkbox"/> Undeclared / Not Known <input type="checkbox"/> Other Ethnic Origin (please state)	
B9	THE PERSON'S SEXUAL ORIENTATION <i>(Tick one box only)</i>	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Undeclared <input type="checkbox"/> Not Known	
B10	RELIGION OR BELIEF	<input type="checkbox"/> None <input type="checkbox"/> Christian <input type="checkbox"/> Hindu <input type="checkbox"/> Muslim <input type="checkbox"/> Any other religion <input type="checkbox"/> Not Stated <input type="checkbox"/> Buddhist <input type="checkbox"/> Jewish <input type="checkbox"/> Sikh	
B11	OTHER DISABILITY <i>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.</i> <i>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.</i>	<input type="checkbox"/> Physical Disability: Hearing Impairment <input type="checkbox"/> Physical Disability: Visual Impairment <input type="checkbox"/> Physical Disability: Dual Sensory Loss <input type="checkbox"/> Physical Disability: Other <input type="checkbox"/> Mental Health needs: Dementia <input type="checkbox"/> Mental Health needs: Other <input type="checkbox"/> Learning Disability <input type="checkbox"/> Other Disability (none of the above) <input type="checkbox"/> No Disability	
PLEASE SIGN AND DATE THIS FORM			
Print name		Date	
Signature		Date I have informed any interested persons of the request for a DoLS authorisation	

Part C - URGENT AUTHORISATION

Only complete this section if you need to grant an urgent authorisation because it appears to you that the deprivation of liberty is already occurring, or about to occur, and you reasonably think all of the following conditions are met:

- 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 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

I hereby confirm that the Relevant Person meets all the above criteria.

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:

Print name		Date	
Signature			

Part D - 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

Print name	<input type="text"/>	Date	<input type="text"/>
Signature	<input type="text"/>		

DOLS OFFICE USE ONLY

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 part D of the form.**

Part D - RECORD THAT THE DURATION OF THIS URGENT AUTHORISATION HAS BEEN EXTENDED

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:

Print Name	<input type="text"/>	Date	<input type="text"/>
Signature	<input type="text"/>		