

Case ID Number:

**DEPRIVATION OF LIBERTY SAFEGUARDS FORM 1**  
**REQUEST FOR STANDARD AUTHORISATION AND URGENT AUTHORISATION**

Request a **Standard Authorisation** only (***you DO NOT need to complete pages 6 or 7***)

Grant an **Urgent Authorisation** (***please ALSO complete pages 6 and 7 if appropriate/required***)

Full name of person being deprived of liberty

Sex

Date of Birth (*or estimated age if unknown*)

Est. Age

Relevant Medical History (*including diagnosis of mental disorder if known*)

Sensory Loss

Communication Requirements

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)

Usual address of the person, (if different to above)

Telephone Number

Name of the Supervisory Body where this form is being sent

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

## 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 describe the care and / or treatment this person is receiving or will receive 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, types of choice the person has and any medical treatment they receive.*

- *Explain why the person is or will not be free to leave and why they are under continuous or complete supervision and control.*
- *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.)*
- *Indicate the frequency of the restrictions you have put in place.*

**INFORMATION ABOUT INTERESTED PERSONS AND OTHERS TO CONSULT**

|   |           |  |
|---|-----------|--|
| Family member or friend   | Name      |  |
|   | 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 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 |  | <i>If Yes please describe further e.g. application/order/direction, community treatment order, guardianship</i> |
|-----|--|----|--|---|

**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       |  |

**I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A DoLS AUTHORISATION** *(Please sign to confirm)*

| <b>RACIAL, ETHNIC OR NATIONAL ORIGIN</b>  |  |  |  |
|---|--|--|--|
| <i>Place a cross in one box only</i>  |  |  |  |
| White   |  | Mixed / Multiple Ethnic groups         |  |
| Asian / Asian British   |  | Black / Black British                  |  |
| Not Stated  |  | Undeclared / Not Known                 |  |
| Other Ethnic Origin ( <i>please state</i> )   |  |  |  |
| <b>THE PERSON'S SEXUAL ORIENTATION</b>  |  |  |  |
| <i>Place a cross in one box only</i>  |  |  |  |
| Heterosexual  |  | Homosexual                             |  |
| Bisexual  |  | Undeclared                             |  |
| Not Known   |  |  |  |
| <b>OTHER DISABILITY</b>   |  |  |  |
| <p><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></p> <p><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></p> <p style="text-align: right;"><i>Place a cross in one box only</i></p> |  |  |  |
| 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   |  |  |  |
| <b>RELIGION OR BELIEF</b>   |  |  |  |
| <i>Place a cross in one box only</i>  |  |  |  |
| None  |  | Not stated                             |  |
| Buddhist  |  | Hindu                                  |  |
| Jewish  |  | Muslim                                 |  |
| Sikh  |  | Any other religion                     |  |
| Christian<br>(includes Church of Wales, Catholic, Protestant and all other Christian denominations)   |  |  |  |

**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**

**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 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.***

This Urgent Authorisation will expire at the end of the day on:

Signed

Print name

Date

Time

**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:

|  |            |  |      |  |
|--|------------|--|------|--|
| <b>SIGNED</b><br>(on behalf of the Supervisory Body) | Signature  |  |      |  |
|  | Print Name |  |      |  |
|  | Date       |  | Time |  |