Isle of Wight Council Deprivation of Liberty Safeguards
County Hall,
Floor 2
Newport
PO30 1UD

Isle of Wight Council

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)***			**X**
Grant an **Urgent Authorisation** ***(please ALSO complete pages 6 and 7 if appropriate/required)***			
Full name of person being deprived of liberty	*The name the person was born with + include any middle names*	Sex *Male/ Female/Non-binary*	
Date of Birth *(or estimated age if unknown)*	*Please ensure this is correct*	Est. Age *Not needed if the DOB is correct*	

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

This section explains why the person lacks the mental capacity to consent to their care/treatment.

- *Do they have dementia?*
- *Other mental health issues?*
- *A temporary confusion e.g. UTI, delirium?*
- *Do you feel that because of their cognitive impairment, the person lacks the mental capacity to consent to the care/treatment they are receiving, if so, why?*

Sensory Loss	*Any hearing problems* *Any eyesight problems*	Communication Requirements	*Can they verbally communicate their views and needs?* *Is another language their first language?* *Do they need an interpreter?*
Name and address of the care home or hospital requesting this authorisation		*Full name and address of where this person is currently residing including the Ward or Unit name*	
Telephone Number	*Please ensure you provide a telephone number.*		
Person to contact at the care home or hospital, (including ward details if appropriate)	Name	*The best person who can comment on the person you are applying for a DoLS for.*	
	Telephone		
	Email		
	Ward (if appropriate)		

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Usual address of the person, (if different to above)	*Where does the person usually live?*			
Telephone Number				
Name of the Supervisory Body where this form is being sent	*Isle of Wight Council*			
How the care is funded *If this person is leaving hospital under NHS funding, do you know who will fund the placement afterwards? Please include both.*	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*	The date from which the person resides with you or from when they are being deprived of their liberty.

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.*

- *When did the person move into your care home or be admitted into hospital?*
- *Who made the decision for this person to move into your care home or hospital?*
- *How long will the person be staying with you?*
- *Why have they moved into your care home or been admitted into hospital?*
- *Where were they before?*
- *What care/treatment are you providing – personal care, administering medication etc*
- *Is care being given by one person or more than one?*
- *Is any equipment being used e.g. hoists.*
- *Is the person resistive to support, if so, when and how often?*

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- *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.*

- *What restrictions are in place e.g. locked doors, sensor mats, is the person confined within a specific location, are there night-time checks, are there bedrails in place, are they being monitored by staff at any point?*
- *Are they on any medication with a sedating effect such as antipsychotics, sleeping aids, PRN medication?*
- *Is medication being administered covertly?*
- *Is there any physical restraint used?*
- *Are there any restrictions around the person smoking or drinking alcohol?*
- *Are there any restrictions around contact with other people e.g. family?*
- *Are they asking or making physical attempts to leave where they are residing?*
- *Is there any time when the person's whereabouts are not known?*

INFORMATION ABOUT INTERESTED PERSONS AND OTHERS TO CONSULT		
Family member or friend *Please indicate the relationship to the person who is being deprived.*	Name	
	Address	
	Telephone	
	Name	

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Anyone named by the person as someone to be consulted about their welfare	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 *Please indicate if the LPA relates to health and welfare.*	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 *Has an IMCA been involved with this person previously that you're aware of?*	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	*Please tick one of these boxes*
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*	

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The person has made an Advance Decision that is valid and applicable to some or all of the treatment	*Please tick one of these boxes*
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*

Have you requested someone assess the person for consideration under the Mental Health Act?

OTHER RELEVANT INFORMATION

Names and contact numbers of regular visitors not detailed elsewhere on this form:

Any other relevant information including safeguarding issues:

Are you aware of any safeguarding concerns involving the person who is being deprived of their liberty?

PLEASE NOW SIGN AND DATE THIS FORM

Signature	*Please sign this section.*	Print Name	
Date	*Date you are sending in the request.*	Time	
I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A DoLS AUTHORISATION *(Please sign to confirm)*		*This confirms that you have told the person's next of kin/ family / relevant people involved about the DoLS.*	

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)			

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 describe further on page 2***	
The person lacks capacity to make their own decision about whether to be accommodated here for care or treatment	

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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	*You **only** sign this section if you are requesting an urgent authorisation as well as a standard authorisation.*	Print name	
Date		Time	

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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 <u>does not</u> 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	*Care homes and hospital wards do not sign this section of the form.*		
	Print Name			
	Date		Time	