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| Case ID Number:  |
| **DEPRIVATION OF LIBERTY FORM 1(X)****REQUEST FOR AUTHORISATION BY THE COURT OF PROTECTION** |
| 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 |  | CommunicationRequirements |   |
| Name and address of the Managing Authority / Service Provider / Other person making the request |  | Tel. No. |  |
| Person to contact | Name |  |
| Telephonenumber |  | Email address: |  |
| Other info. |  |
| Usual address of the relevant person, (if different to above) |  | Telephone Number |  |
| Name of the Local Authority / Clinical Commissioning Group 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 |  |
| Does the person have the mental capacity to consent to the sharing of information with the GP regarding the DoLS application? | Yes☐ | No☐ | If Yes, do they consent to information sharing? | Yes☐ | No☐ |
| If the person lacks the mental capacity to consent, has a best interests decision been taken to share information with the GP? | Yes☐ | No☐ |
| Has the GP been informed? | Yes☐ | No☐ |
| Have appropriate family members, friends, or others named by the relevant person, been informed about this DoLS application? | Yes☐ | No☐ |
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| **REQUEST FOR DEPRIVATION OF LIBERTY AUTHORISATION**  |
| **THE DATE FROM WHICH THE AUTHORISATION IS REQUIRED:** |  |
| **PURPOSE OF THE 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.*
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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.*
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| **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 |  |

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| **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 or Service Provider 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* |
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| **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)* |  |