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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Case ID Number: **To be Completed by Supervisory body** | | | | | | | | | | | | | | | | |
| **DEPRIVATION OF LIBERTY SAFEGUARDS FORM 2**  **REQUEST FOR A FURTHER STANDARD AUTHORISATION** | | | | | | | | | | | | | | | | |
| **Full name of person being deprived of their liberty** | | | | | | | |  | | | | | | **Sex** |  | |
| **Date of Birth**  *(or estimated age if unknown)* | | | | | | | |  | | | | | | **Est. Age** |  | |
| **Relevant Medical History –** please provide up to date details of any relevant medical conditions which may need to be taken into account by the assessor | | | | | | | | | | | | | | | | |
| **G.P. Name** | | | | |  | |  | | | | | | | | | |
| **Practice Address** | | | | | | |  | | | | | | | | | |
| **Telephone No:** | | | | | | |  | | | | | | | | | |
| **E-mail address** | | | | | | |  | | | | | | | | | |
| **Relevant Medical History:** | | | | | | |  | | | | | | | | | |
| **Sensory Loss**  *Please provide details* | | |  | | | | | | **Communication**  **Requirements**  *Please provide details* | | |  | | | | |
| **Name of care home or hospital** requesting this new authorisation | | | | | | | | |  | | | | | | | |
| **Address** **of the care home or hospital** requesting this new authorisation | | | | | | | | | Post code | | | | | | | |
| **Person to contact at the care home or hospital, (including ward details if appropriate)** | | | | | | **Name** | | |  | | | | | | | |
| **Telephone** | | |  | | | | | | | |
| **Email** | | |  | | | | | | | |
| **Ward (if appropriate)** | | |  | | | | | | | |
| **Name of the Supervisory Body where this form is being sent** | | | | | | | | | **Doncaster Metropolitan Borough Council** | | | | | | | |
| |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **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) | | | | | | | |  | | | | | | | | | | | | | | | | | |
| **THE PURPOSE OF THE AUTHORISATION is to enable the following care and / or treatment to be given:** | | | | | | | | | | | | | | | | |
| * *Please describe the care and / or treatment this person is receiving day-to-day and* ***attach an up to date care plan.*** * *Please* ***give as much detail as possible*** *about the type of care the person is receiving on a day to day basis. This will include details of personal care and support, supervision, help with mobility and medication, support with behavioural issues, types of choice the person has and any medical treatment they receive.* * *Types and duration of* ***restrictions*** *and* ***restraint*** *used if any and descriptions of all care plans, behaviour charts or other indications of the level of the person’s care needs.* | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **THE DATE FROM WHICH THE NEW STANDARD AUTHORISATION IS SOUGHT:**  A further Standard Authorisation is required to start on this date  because the existing Standard Authorisation expires at this time. | | | | | | | | | | | | | | | | |
| **OTHER RELEVANT INFORMATION – UPDATE ON CURRENT SITUATION** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| *Please include details of any changes in the care plan, medical information, person’s behaviour or visitors since the current Standard Authorisation was given.* | | | | | | | | | | | | | | | | |
| **CONDITIONS TO WHICH THE PREVIOUS STANDARD AUTHORISATION IS SUBJECT:** | | | | | | | | | | | | | | | | |
| This current standard authorisation is **NOT** subject to any conditions | | | | | | | | | | | | | | | |  |
| This current standard authorisation **IS** subject to the following conditions | | | | | | | | | | | | | | | |  |
| *Where conditions are placed on a current authorisation please indicate whether or not they have been met and the action you have taken.* | | | | | | | | | | | | | | | |  |
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| **RELEVENT PERSON REPRESENTATIVE (RPR)** | | | | | | | | | | | | | | | | |
| **Name of RPR :** | | | |  | | | | | |  | | | | | | |
| *Please provide details of whether or not you believe the appointed relevant person representative is able to meet their role in :-*  • *maintaining regular contact with the person being deprived of their liberty- do they visit regular?*  *• representing and supporting the person in all matters relating to the Deprivation of Liberty, including, if appropriate, requesting a review, using an organisation’s complaints procedure on the person’s behalf or making an application to the Court of Protection where the person is objecting to the placement and the care and treatment* | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| Signature  *Type name* | |  | | | | | | | | | Print name | |  | | | |
| Position | |  | | | | | | | | | | | | | | |
| Date | |  | | | | | | | | | Time | |  | | | |
| **I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A FURTHER DoLS AUTHORISATION,** *(Please type name or sign to confirm)* | | | | | | | | | | |  | | | | | |