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| --- | --- | --- | --- | --- | --- | --- |
| Case ID Number: | | | | | | |
| **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 | |  | |
| Name and Address of Managing Authority (care home or hospital) requesting this authorisation |  | | | | | |
| Person to contact at the care home or hospital, (include ward details if appropriate) | Name |  | | | | |
| Telephone |  | | | | |
| Email |  | | | | |
| Ward (*if appropriate)* |  | | | | |
| **SECTION A: The purpose of the authorisation is to enable the following care and / or treatment to be given:** | | | | | | |
|  | | | | | | |
| **SECTION B: Please answer ALL questions** | | | | | | |
| Has there been **ANY** change in the person’s presentation since the last standard authorisation? | | | | **YES** | | **NO** |
| Has there been **ANY** changes in restrictions? | | | | **YES** | | **NO** |
| Is the person becoming distressed about, or is objecting to, being in the care home/hospital? | | | | **YES** | | **NO** |
| Are any family members expressing objections to, or distress about, the person being accommodated in the care home/hospital? | | | | **YES** | | **NO** |
| Are any family members not in agreement with the care and treatment being provided? | | | | **YES** | | **NO** |
| Are there any issues of incompatibility with other residents? | | | | **YES** | | **NO** |
| Is there any evidence of challenging behaviour requiring significant restrictions? | | | | **YES** | | **NO** |
| Is there a lack of clarity in regards to the diagnosis of mental disorder, **OR** is the mental disorder changeable? | | | | **YES** | | **NO** |
| Is the person’s mental capacity to agree to their accommodation, care and treatment fluctuating or variable? | | | | **YES** | | **NO** |
| Are there any Adult safeguarding concerns? | | | | **YES** | | **NO** |
| Has the administration of covert medication started within the period of the current authorisation? | | | | **YES** | | **NO** |

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| **If you have answered YES to ANY questions in section B, please provide details of the circumstances below:** | | | | | | |
|  | | | | | | |
| **Conditions** *please indicate* | | | | | | |
| 1. Does the current authorisation include any conditions? | | | | | **YES** | **NO** |
| 2. If YES have they been successfully implemented? | | | | | **YES** | **NO** |
| *If you answered NO to question 2 please indicate reasons* | | | | | | |
| **Please state the persons’ mental disorder or impairment of the mind (diagnosed/undiagnosed)** | | | | | | |
|  | | | | | | |
| **Is the person considered to be “end of life” or receiving palliative care? (provide details)** | | | | | | |
|  | | | | | | |
| **Current Relevant Person’s Representative – RPR (including paid RPR / IMCA) CONTACT DETAILS** | | | | | | |
| Name | |  | | | | |
| Address | |  | | | | |
| Contact Number | |  | | | | |
| Do they visit **AT LEAST** every 3 months? | | | | | **YES** | **NO** |
| **Are there ANY professionals involved? (Social Worker / CPN / CHC team)** | | | | | | |
| **Name** | | **Role** | **Contact number** | | | |
|  | |  |  | | | |
|  | |  |  | | | |
| **THE DATE FROM WHICH THE STANDARD AUTHORISATION IS SOUGHT:** | | | | | | |
| A further Standard Authorisation is required to start on this date  so it is force immediately after the expiry of the existing Standard  Authorisation. | | | | | | |
|  | | | | | | |
| Signature |  | | Print name |  | | |
| Date |  | | Time |  | | |
| **I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A FURTHER STANDARD AUTHORISATION** *(Please sign to confirm)* | | |  | | | |