

Case ID Number:			
DEPRIVATION OF LIBERTY SAFEGUARDS FORM 4 MENTAL CAPACITY, MENTAL HEALTH, and ELIGIBILITY ASSESSMENTS			
This combined form contains 3 separate assessments; if any assessment is negative there is no need to complete the others unless specifically commissioned to do so by the Supervisory Body.			
Please indicate which assessments have been completed <i>(*Supervisory Bodies will vary in practice as to who completes the Mental Capacity assessment)</i>			
Mental Capacity*		Mental Health	Eligibility
This form is being completed in relation to a request for a standard authorisation.			
This form is being completed in relation to a review of an existing Standard Authorisation under Part 8 of Schedule A1 to the Mental Capacity Act 2005.			
Full name of the person being assessed			
Date of birth <i>(or estimated age if unknown)</i>		Est. Age	
Name of the care home or hospital where the person is, or may become, deprived of liberty			
Name and address of the Assessor			
Profession of the Assessor			
Name of the Supervisory Body			
The present address of the person being assessed if different from the care home or hospital stated above.			

MENTAL CAPACITY ASSESSMENT	
The following practicable steps have been taken to enable and support the person to participate in the decision making process:	
In my opinion the person LACKS capacity to decide whether or not they should be accommodated in this hospital or care home for the purpose of being given the proposed care and/or treatment, and the person is unable to make this decision because of an impairment of, or a disturbance in the functioning of, the mind or brain.	
In my opinion the person HAS capacity to decide whether or not they should be accommodated in this hospital or care home for the purpose of being given the proposed care and/or treatment	
Stage One: What is the impairment of, or disturbance in the functioning of the mind or brain?	
Stage Two: Functional test	
a. The person is unable to understand the information relevant to the decision <i>Record how you have tested whether the person can understand the information, the questions used, how you presented the information and your findings.</i>	
b. The person is unable to retain the information relevant to the decision <i>Record how you tested whether the person could retain the information and your findings. Note that a person's ability to retain the information for only a short period does not prevent them from being able to make the decision.</i>	
c. The person is unable to use or weigh that information as part of the process of making the decision <i>Record how you tested whether the person could use and weigh the information and your findings.</i>	
d. The person is unable to communicate their decision (whether by talking, using sign language or any other means) <i>Record your findings about whether the person can communicate the decision.</i>	
Stage Three: Explain why the person is unable to make the specific decision because of the impairment of, or disturbance in the functioning of, the mind or brain.	

MENTAL HEALTH ASSESSMENT

In carrying out this assessment, I have taken into account any information given to me, and any submissions made by any of the following:

- (a) The relevant person's representative
- (b) Any IMCA instructed for the person in relation to their deprivation of liberty
- (c) I have consulted the Best Interests Assessor for any relevant information about possible objections to treatment, including whether any donee or Deputy has made a valid decision to consent to any mental health treatment.

Place a cross in **EITHER** box below

In my opinion the person IS NOT suffering from a mental disorder within the meaning of the Mental Health Act 1983 (disregarding any exclusion for persons with learning disability).	
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Provide a rationale for your opinion, including details of their symptoms, diagnosis and behaviour

In my opinion the person IS suffering from a mental disorder within the meaning of the Mental Health Act 1983 (disregarding any exclusion for persons with learning disability).	
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Provide a rationale for your opinion, including details of their symptoms, diagnosis and behaviour

In my opinion, the person's mental health and wellbeing is likely to be affected by being deprived of liberty in the following ways:

ELIGIBILITY ASSESSMENT

Reference to Cases A to E refers to the cases of ineligibility for DoLS described in **MCA Schedule 1A**

Answer **ALL** of the following questions Yes or No, by placing a cross in the relevant box.

The person is detained under section 2, 3, 4, 35-38, 44, 45A, 47, 48 or 51 of the Mental Health Act 1983(Case A).	Yes	
	No	
The person is subject to s17 leave or conditional discharge (Case B), or Community Treatment Order (Case C), or Guardianship (Case D), and a Standard Authorisation would be incompatible with a Mental Health Act requirement (e.g. as to residence)	Yes	
	No	

If you have answered "Yes" to either of the above, the person is ineligible for DoLS.
Please give reasons/explanation for your answer:

Hospital Cases Only (Case E)

The purpose of detention is to receive medical treatment for mental disorder <i>Please explain further:</i>	Yes	
	No	
In my opinion this person could be detained under the Mental Health Act (on the assumption that the person cannot be assessed and treated under the Mental Capacity Act 2005 <i>Please explain further:</i>	Yes	
	No	

**If the answer to both of the above statements is YES please consider the next two statements
If either of the below are ticked the person is ineligible for DoLS**

The person objects, or would object if able to do so, to some or all of the medical treatment for a mental disorder <i>Please explain further:</i>	Yes	
Are the deprivation of liberty safeguards the least restrictive way of best achieving the proposed care and treatment? <i>Describe the least restrictive way of best achieving the proposed care and treatment:</i>	No	

PLEASE NOW SIGN AND DATE THIS FORM

Signed		Date	
Print Name		Time	

In order to safeguard their rights please request that the person is assessed under the Mental Health Act and confirm this below:

CONFIRMATION OF REQUEST FOR MENTAL HEALTH ACT ASSESSMENT

Date and Time of request for Mental Health Act Assessment	
Name of Person to which the request was made	