Customer Portal User Guide (DoLS)

This user guide will provide the user with the information they require to complete the request in relation to: Deprivation of Liberty Safeguards (DoLS).
The Forms that will be covered are as follows:

• FORM 1 – Request for Standard/Urgent DoLS Authority
• FORM 2 – Request for Further Authority for Standard Authorisation
• FORM 7 – Request for DoLS Suspension
• FORM 10 – Request for DoLS Review
Welcome to the Suffolk Adult Care Portal

Please select Professionals

Information and areas specific to Professionals working with Suffolk County Council
Please select
Deprivation of Liberty Safeguards (DoLS)

Please select Appropriate Form
Completing a FORM 1: Request for Standard Authorisation and Urgent Authorisation
Please ONLY select ‘Someone else in a professional Capacity’

This information will be completed automatically from your registration details.

Entered your relationship to customer

CUSTOMER FIRST NAME [to be entered here]

CUSTOMER LAST NAME [to be entered here]

CUSTOMER DOB [to be entered here]

[Select gender from drop down list]

[Select gender from drop down list]

CUSTOMER NHS No. [to be entered here, if known]

Please enter ‘Post Code’ & select ‘Find Address’
Select the appropriate address from the list provided.
# Request for a Standard and Urgent Authorisation

## INFORMATION

1. **Type of Request**
   - [ ] Request a **Standard Authorisation** only
   - [ ] Grant an **Urgent Authorisation**

2. **Your Details**
   - Name
   - Address
   - Telephone
   - Email

3. **Request for Standard Authorisation**
   - [ ] Relevant Medical History

4. **Type of Request**
   - [ ] Request a **Standard Authorisation** only
   - [ ] Grant an **Urgent Authorisation**

5. **Communication Requirements**
   - [ ] Sensory Loss

6. **Supporting Documents**
   - [ ] Name and address of the care home or hospital requesting this authorisation

7. **Submit Request**
   - [ ] Name of the Supervisory Body where this form is being sent

8. **How the care is funded**
   - [ ] Local Authority
   - [ ] NHS
   - [ ] Self-funded by person
   - [ ] Local Authority and NHS

9. **Please provide funding details**
   - [ ] Other

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**If shared funding Please provide details here**
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

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.

The date from which the standard authorisation is required:

- Request a Doc.S
- Your Details
- Information
- Request for Standard Authorisation
- Information about interested persons and others to consult
- IMCA Instruction
- Request for an Extension to the Urgent Authorisation
- Supporting Documentation
- Submit Request

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.

- 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.
<table>
<thead>
<tr>
<th>FAMILY OR STRAND</th>
<th>NAME</th>
<th>ADDRESS</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anyone named by the person as someone to be consulted about their welfare</td>
<td>Name</td>
<td>Address</td>
<td>Telephone</td>
</tr>
<tr>
<td>Anyone engaged in caring for the person or interested in their welfare</td>
<td>Name</td>
<td>Address</td>
<td>Telephone</td>
</tr>
<tr>
<td>Any donee of a Lasting Power of Attorney granted by the person</td>
<td>Name</td>
<td>Address</td>
<td>Telephone</td>
</tr>
<tr>
<td>Any Personal Welfare Deputy appointed for the person by the Court of Protection</td>
<td>Name</td>
<td>Address</td>
<td>Telephone</td>
</tr>
<tr>
<td>Any IMCA instructed in accordance with sections 37 to 39D of the Mental Capacity Act 2005</td>
<td>Name</td>
<td>Address</td>
<td>Telephone</td>
</tr>
</tbody>
</table>

**Request for a Standard and Urgent Authorisation**

<table>
<thead>
<tr>
<th>INFORMATION ABOUT INTERESTED PERSONS AND OTHERS TO CONSULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
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**INFORMATION ABOUT INTERESTED PERSONS AND OTHERS TO CONSULT**

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<tr>
<td>Name</td>
<td>Address</td>
<td>Telephone</td>
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</table>

**Purpose**

- Name
- Address
- Telephone
### Request for a Standard and Urgent Authorisation

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>Request a DoLS</td>
</tr>
<tr>
<td>2.</td>
<td>Your Details</td>
</tr>
<tr>
<td>3.</td>
<td>Information</td>
</tr>
<tr>
<td>4.</td>
<td>Request for Standard Authorisation</td>
</tr>
<tr>
<td>5.</td>
<td>Information about interested persons and those to consult</td>
</tr>
<tr>
<td>6.</td>
<td>IMCA Instruction</td>
</tr>
<tr>
<td>7.</td>
<td>Request for an Extension to the Urgent Authorisation</td>
</tr>
<tr>
<td>8.</td>
<td>Submit Request</td>
</tr>
<tr>
<td>9.</td>
<td>Submit Request</td>
</tr>
</tbody>
</table>

### Other Relevant Information
- Names and contact numbers of regular visitors not detailed elsewhere on this form:
- Any other relevant information including safeguarding issues:

#### IMCA Instruction
- Whether it is necessary for an independent Mental Capacity Advocate (IMCA) to be instructed:
  - 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:
  - The person has made an Advance Decision that is valid and applicable to some or all of the treatment
  - 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

#### Please Provide names of people that have been informed

---

**Please Provide names of people that have been informed**
ONLY COMPLETE THIS SECTION IF YOU NEED TO GRANT AN URGENT AUTHORISATION BECAUSE IT APPEARS TO YOU THAT THE DEPRIVATION OF LIBERTY IS ALREADY OCCURRING, 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 16 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
- 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
- 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

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: __________ days

This Urgent Authorisation will expire at the end of the day on: __________

Signed: __________
Print name: __________
Date: __________
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 now sign, date and send to the SUPERVISORY BODY for authorisation.

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 does not 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

Date

Name

Date

Time
Please select ‘Upload Document’ and locate supporting document from internal filing structure and attach file. The file name will appear above the ‘Upload Document’ button.
Please select 'Send Request to Suffolk' to submit the request.

PLEASE NOTE: If you require a copy of this form for future reference select the PDF button prior to submission and save a copy to your locate filing system.
Completing a FORM 2: Request for a Further Standard Authorisation
DEPRIVATION OF LIBERTY SAFEGUARDS FORM 2
REQUEST FOR A FURTHER STANDARD AUTHORISATION

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)

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 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 needs, medication, support with behavioural issues, types of choice the person has and any related treatment they require.

THE DATE FROM WHICH THE STANDARD AUTHORISATION IS SOUGHT:
A further Standard Authorisation is required to start on this date as it is force immediately after the expiry of the existing Standard Authorisation.

REQUEST FOR A FURTHER STANDARD AUTHORISATION

Name and address of the care home or hospital requesting this authorisation

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 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 needs, medication, support with behavioural issues, types of choice the person has and any related treatment they require.

The date from which the standard authorisation is sought:

A further Standard Authorisation is required to start on this date as it is force immediately after the expiry of the existing Standard Authorisation.

Other Relevant Information
Please include details of any changes previously given in Form 1 e.g. in the care plan, medical plan, personal plan, behaviour in matters.

I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A FURTHER STANDARD AUTHORISATION
(please sign to certify)

Date: dd-mm-yyyy
OTHER RELEVANT INFORMATION

Please include details of any changes previously given in Form 1 e.g. in the care plan, medical information, person's behaviour or visitors.

Signature
Date

I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A FURTHER STANDARD AUTHORISATION (Please sign to confirm)

Please Provide names of people that have been informed

Request for a Further Standard Authorisation

1. Extend a DLS
2. Your Details
3. Request for a Further Standard Authorisation
4. Supporting Documents
5. Submit Request

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 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, medication, medication, support with behavioural issues, types of mobile the person has and any medical treatment they require.

The date from which the standard authorisation is taken:

A further Standard Authorisation is required to start on this date as it is from immediately after the expiry of the existing Standard Authorisation.

Other Relevant Information

Please include details of any changes previously given in Form 1 e.g. in the care plan, medical information, person's behaviour or visitors.

I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A FURTHER STANDARD AUTHORISATION (Please sign to confirm)

Date
Please select "Upload Document" and locate supporting document from internal filing structure and attach file. The file name will appear above the "Upload Document" button.
Submit Application Page

Please select 'Send Request to Suffolk' to submit the request.

PLEASE NOTE: If you require a copy of this form for future reference select the PDF button prior to submission and save a copy to your locate filing system.
Completing a FORM 7: Suspension of Standard Authorisation
Request for Suspension of DoLS Episode

INTRODUCTION

How does this tool work?

You can complete this form for yourself or on behalf of someone else

i.e. if you are a carer, relative, friend or professional.

How to Navigate

Click on the numbered sections on the left hand side of the window

or

use the Next and Previous options to move through the pages.

Don’t use the browser ‘back’ button

The Form

Questions

You DO NOT need to answer every question, you need only complete what is relevant.

The form uses many different types of questions, including lists and text fields

Options

Save the Form

Use the Save for Later option to Save the form to return to at any time.

Print the Form

Use the option to Print a copy of the form if required.
Please ONLY select ‘Someone else in a professional Capacity’

This information will be completed automatically from your registration details

Entered your relationship to customer

CUSTOMER FIRST NAME [to be entered here]

CUSTOMER LAST NAME [to be entered here]

CUSTOMER DOB [to be entered here]

[Select gender from drop down list]

[Select gender from drop down list]

CUSTOMER NHS No. [to be entered here, if known]

Please enter ‘Post Code’ & select ‘Find Address’

Select the appropriate address from the list provided
**Request for Suspension of DoLS Episode**

**Suspension of Standard Authorisation**

Notice that the Person no longer meets the Eligibility Requirement

The above person no longer meets the eligibility requirement for a Standard Authorisation under Schedule A1 to the Mental Capacity Act 2005.

The Standard Authorisation is suspended from the time this notice is given.

The Standard Authorisation no longer authorises the care home or hospital to deprive the person of their liberty for as long as it is suspended.

Reason why the Person no longer meets the Eligibility Requirement

Please select one of the reasons below with reference to Schedule A1 to the Mental Capacity Act 2005.

- The person is now detained in a hospital under one of the following sections of the Mental Health Act 1983: sections 2, 3, 4, 5, 38, 44, 45A, 47, 49 or 51.
- Accommodating the person in this care home or hospital new conflicts with a requirement imposed upon them in connection with their liability to detention under the Mental Health Act 1983.
- Accommodating the person in this care home or hospital new conflicts with a requirement imposed under the Mental Health Act 1983, Guardianship or Community Treatment Order for example.
- Accommodating the person in this care home or hospital new conflicts with a Guardianship Order.

Signed (on behalf of the Managing Authority):

<table>
<thead>
<tr>
<th>Name</th>
<th>Date: dd-mm-yyyy</th>
</tr>
</thead>
</table>

Date of notice (also the date on which the Standard Authorisation is suspended):

| dd-mm-yyyy |GRAMENT-01 |

_previous_
<table>
<thead>
<tr>
<th>Please select one option</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOTICE THAT THE RELEVANT PERSON MEETS THE ELIGIBILITY REQUIREMENT AGAIN</td>
</tr>
<tr>
<td>During the previous 28 days the Managing Authority gave the Supervisory Body notice that the above person no longer met the eligibility requirement for a Standard Authorisation. The effect of that notice was to suspend the Standard Authorisation.</td>
</tr>
<tr>
<td>The Managing Authority now gives the Supervisory Body notice that the person once again meets the eligibility requirement for the following reasons and the Standard Authorisation ceases to be suspended when this notice is given.</td>
</tr>
<tr>
<td>Signed</td>
</tr>
<tr>
<td>Print Name</td>
</tr>
<tr>
<td>NOTICE THAT THE STANDARD AUTHORISATIONS HAS CEASED TO BE IN FORCE</td>
</tr>
<tr>
<td>28 days or more have lapsed starting on the date on which the Standard Authorisation was suspended. In that time, the suspension has not ceased to be suspended. The Standard Authorisation ceased to have effect at the end of the 28 day period (give date):</td>
</tr>
<tr>
<td>Signed</td>
</tr>
<tr>
<td>Print Name</td>
</tr>
</tbody>
</table>
Supporting Documentation Page

Request for Suspension of DoLS Episode

SUPPORTING DOCUMENTS

You will only be able to attach the following file types:
- Word Documents
- PDF Files
- Images (in .jpg / .png format)

Please select "Upload Document" and locate supporting document from internal filing structure and attach file. The file name will appear above the ‘Upload Document’ button.
Submit Application Page

Request for Suspension of DoLS Episode

Please select 'Send Request to Suffolk' to submit the request.

PLEASE NOTE: If you require a copy of this form for future reference select the PDF button prior to submission and save a copy to your locate filing system.
Completing a FORM 10: Request for a Further Standard Authorisation
Please ONLY select 'Someone else in a professional Capacity'.

This information will be completed automatically from your registration details.

- Enter your relationship to customer
- CUSTOMER FIRST NAME [to be entered here]
- CUSTOMER LAST NAME [to be entered here]
- CUSTOMER DOB [to be entered here]
- [Select gender from drop down list]
- [Select gender from drop down list]
- CUSTOMER NHS No. [to be entered here, if known]

Please enter 'Post Code' & select 'Find Address'. Select the appropriate address from the list provided.
# Request for a DoLS Review

## DEPRIVATION OF LIBERTY SAFEGUARDS FORM 10
### REVIEW

<p>| | |</p>
<table>
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<th></th>
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<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
</tr>
<tr>
<td>2</td>
<td>Your Details</td>
</tr>
<tr>
<td>3</td>
<td>Review</td>
</tr>
<tr>
<td>4</td>
<td>Review to Case or DoLS Authorisation</td>
</tr>
<tr>
<td>5</td>
<td>Supporting Documents</td>
</tr>
<tr>
<td>6</td>
<td>Submit Request</td>
</tr>
</tbody>
</table>

### Review Form Details

- **Form Start Date**: dd-mm-yyyy
- **Form End Date**: dd-mm-yyyy

### Name and Address of Organisation or Person Requesting the Review

- **Name**:
- **Telephone**:
- **Email**:

### Contact Details of Organisation or Person Requesting the Review

- **Name**:
- **Telephone**:
- **Email**:

### Review

**A Review of the current authorisation is requested on the following grounds**

- The person no longer meet the Age, No Refusal, Mental Capacity, Mental Health or Best Interests requirements, or the reason why they meet the requirements has changed
- The conditions attached to the Standard Authorisation need to be varied because there has been a change in the person's circumstances

Please give details:

- The person no longer meet the Age, No Refusal, Mental Capacity, Mental Health or Best Interests requirements, or the reason why they meet the requirements has changed
- The conditions attached to the Standard Authorisation need to be varied because there has been a change in the person's circumstances

Please give details:
REVIEW TO CEASE A DOLS AUTHORIZATION

The Managing Authority requests a review, because the person is, or is about to be discharged so the Standard Authorisation will no longer be required. This is on the grounds that the person no longer meets the best interest requirement.

The person has left / is due to leave the care home on

The person is due to be / has been discharged from hospital on

The person’s new address is

This follows a best interest decision (attached) made on

It is no longer in their best interest to be accommodated in this care home or hospital because:

Signed
(on behalf of the Managing Authority)

[Signature]

Print Name

Date

The remainder of this form will be completed by the Supervisory Body

Request for a DoLS Review

REVIEW TO CEASE A DOLS AUTHORIZATION

The Managing Authority requests a review, because the person is, or is about to be discharged so the Standard Authorisation will no longer be required. This is on the grounds that the person no longer meets the best interest requirement.

The person has left / is due to leave the care home on

The person is due to be / has been discharged from hospital on

The person’s new address is

This follows a best interest decision (attached) made on

It is no longer in their best interest to be accommodated in this care home or hospital because:

Please now sign and date this form

Name

Date
Supporting Documentation Page

Request for a DoLS Review

SUPPORTING DOCUMENTS

You will only be able to attach the following file types:
- Word Documents
- PDF Files
- Images (in jpeg/png format)

Please select 'Upload Document' and locate supporting document from internal filing structure and attach file. The file name will appear above the 'Upload Document' button.
Submit Application Page

Submit Request to Suffolk to submit the request.

PLEASE NOTE: If you require a copy of this form for future reference, select the PDF button prior to submission and save a copy to your locate filing system.