Community Deprivation of Liberty   
referral form

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| P v Cheshire West and Chester Council and P & Q v Surrey County Council – the Supreme Court judgement considered the ‘acid test’ to determine whether a deprivation of liberty is occurring.  Under this ruling:   * P is not free to leave * P is under constant supervision * P is under continuous control   And lacks capacity to consent to live at current address to receive assessed level of support |

## About the person potentially being deprived of their liberty

|  |  |
| --- | --- |
| Full name |  |
| Date of birth  *(or estimated age if not known)* |  |
| Gender |  |
| Address  *(where deprivation may be occurring)* |  |
| Phone number  *(at location where deprivation may be occurring)* |  |
| Home address  *(if different to above)* |  |
| Phone number *(If different to above)* |  |
| Medical History |  |

## Details of situation

|  |
| --- |
| Why do you think this person is being deprived of their liberty or are not free to leave?  List any other restrictions in place |
|  |
| Are their family (or any other advocate) in agreement with current arrangement?  If they have any objections state what they are |
|  |
| What support or care does this person receive?  Please detail the type of care the person receives, the number of hours per day, and whether that is 1-1, 2-1 etc. Where known, include details of personal care, mobility, medication, support with behavioural issues etc. |
|  |

## Care provision

Please list the Care Professionals involved in support of this person (e.g. Social Worker, GP, District Nurse, Care Agency, Shared Lives, Carers) (Add as many as are known)

|  |  |
| --- | --- |
| Name |  |
| Phone number |  |
| Email address |  |
| Address |  |

|  |  |
| --- | --- |
| Name |  |
| Phone number |  |
| Email address |  |
| Address |  |

|  |  |
| --- | --- |
| Name |  |
| Phone number |  |
| Email address |  |
| Address |  |

How is the care funded?

Please select from the list below and provide details were needed

|  |  |
| --- | --- |
| Local Authority (please specify which one) |  |
| NHS |  |
| Local Authority and NHS (Jointly funded) |  |
| Self-funded by person |  |
| Funded through insurance |  |
| Other (please specify) |  |

## Referrer details

|  |  |
| --- | --- |
| Full name |  |
| Phone number |  |
| Email address |  |
| Address |  |

Once completed, please send this form to: [dols@brent.gov.uk](mailto:dols@brent.gov.uk)