CASE NUMBER

Mental Capacity Act 2005

DEPRIVATION OF LIBERTY FORM No. 28

BEST INTERESTS ASSESSOR REFERRAL FORM

PART A — BASIC INFORMATION

Full name of the person being deprived of, or being assessed to be deprived of, their liberty	Name	
Name and address of the hospital or care home where the person is being deprived of, or being assessed to be deprived of, their liberty	Name	
	Address	
Person to contact at the hospital or care home	Name	
	Telephone	
	Email	
Name and address of the managing authority responsible for the hospital or care home	Name	
	Address	
Name of the supervisory body instructing the assessor	Name	
Contact / person to receive reports at the supervisory body	Name	
	Address	
	Telehone	
	Email	

PART B – ASSESSMENTS REQUIRED		
		Enter cross(es) as required ⇩
B1	Age assessment **Please record your assessment using Form 5**	☐
B2	Mental capacity assessment **Please record your assessment using Form 7**	☐
B3	No refusals assessment **Please record your assessment using Form 8**	☐
B4	Eligibility assessment **Please record your assessment using Form 9**	☐
B5	Best interests assessment **Please record your assessment using Form 10**	☐

PART C – CONTACT DETAILS OF OTHER ASSESSORS, AND ANY IMCA INVOLVED		
Mental health assessor	Name	
	Telephone	
	Email	
Eligibility assessor (if neither mental health assessor nor best interests assessor)	Name	
	Telephone	
	Email	
IMCA	Name	
	Telephone	
	Email	

PART D– OTHER INFORMATION	
Also appended to this referral request are the following	**(Enter cross if appended) ⇩**
Copy of urgent authorisation (Form 1)	☐

Copy of standard authorisation request (Form 4)		☐
Copy of relevant care plan		☐
Copy of other relevant document(s) **PLEASE SPECIFY**		
Signed (on behalf of the supervisory body)	Signature	
	Print name	
	Position	
Dated	Date	