My Advance Decision to Refuse Treatment

My Name	Any distinguishing features in the event of unconsciousness
Address	Date of Birth
	Telephone Number

What is this document is for?

This advance decision to refuse treatment has been written by me to specify in advance which treatments I don't want in the future. These are my decisions about my healthcare, in the event that I have lost mental capacity and can not consent to or refuse treatment. This advance decision replaces any previous advance decision I have made.

Advice to the reader

I have written this document to identify my advance decision. I would expect any health care professionals reading this document in the event I have lost capacity to check that my advance decision is valid and applicable, in the circumstances that exist at the time.

Please Check

Please do not assume I have lost capacity before any actions are taken. I might need help and time to communicate.

If I have lost capacity please check the validity and applicability of this advance decision.

This advance decision becomes legally binding and must be followed if professionals are satisfied it is valid and applicable. Please help to share this information with people who are involved in my treatment and care and need to know about this.

Please also check if I have made any other statements about my preferences or decisions that might be relevant to my advance decision.

This advance decision does not refuse the offer and or provision of basic care, support and comfort.

My Name	

My advance decision to refuse treatment

I wish to refuse the following specific treatments:	In these circumstances:

(Note to the person making this statement: If you wish to refuse a treatment that is or may be life-sustaining, you must state in the box above that you are refusing that treatment even if your life is at risk as a result. An advance decision refusing life-sustaining treatment must be signed and witnessed).

My Signature (or nominated person)	**Date of Signature**
Witness	Witness Signature
Name	Telephone
Address	Date
Person to be contacted to discuss my wishes:	
Name	**Relationship**
Address	**Telephone**

I have discussed this with (e.g. name of Healthcare Professional)
Profession / Job Title Contact Details Date
I give permission for this document to be discussed with my relatives/carers **YES** **NO** *(please circle one)*
My General Practitioner is: (Name) Address Telephone
Optional Review Comment Date / Time Maker's Signature Witness Signature

The following list identifies which people have a copy and have been told about this Advance Decision to Refuse Treatment (and their contact details)

Name	Relationships	Telephone Number

Further Information (Optional)

I have written the following information that is important to me. It describes my hopes, fears and expectations of life and any potential health and social care problems. It does not directly affect my advance decision to refuse treatment but the reader might find it useful.