Advance Decision to Refuse Treatment

This Advance Decision to Refuse Treatment sets out the situations in which I want to refuse medical treatment should I lack capacity to make or communicate that decision in the future. I have carefully considered these decisions and I confirm that I have capacity to make them. I understand that decisions about my diagnosis and prognosis will be made by the doctor in charge of my care.

Need help filling this in?

If you have any questions please contact the free charity helpline 0800 999 2434 or contact your healthcare professional.

1. About me

Name: _____

Address: _____

Date of birth: _____ NHS number: _____

Distinguishing features: _____

2. GP details

Name: _____ Surgery: _____

Address: _____

Phone number: _____

3. I have discussed this Advance Decision with

4. My refusals of treatment

I confirm that the following refusal(s) of treatment are to apply even if my life is at risk or may be shortened as a result.

I refuse all life-sustaining treatment if:

- I have been diagnosed with any of the conditions I have included in (A) to (D) below, and
- I can no longer make or communicate decisions about my medical treatment, and
- I am unlikely to regain the ability to make these decisions.

I understand life-sustaining treatment includes but is not limited to CPR, clinically assisted nutrition and hydration, artificial or mechanical ventilation and antibiotics for life-threatening infections.

(A) Any type of dementia

Include ☐ Do not include ☐

(B) Brain injury

I understand that brain injury includes but is not limited to stroke, vegetative and minimally conscious states.

Include ☐ Do not include ☐

(C) Diseases of the central nervous system

I understand that a disease of the central nervous system includes but is not limited to motor neurone disease, Parkinson's Disease and Huntington's Disease.

Include ☐ Do not include ☐

(D) Terminal illness

Include ☐ Do not include ☐

(E) Refusing treatment in other situations

I have included additional pages for section 4.E and have attached them to this form ☐

5. To avoid doubt (tick all that apply)

Pain relief

I wish to be given all medical treatment intended to alleviate pain or distress, or aimed at ensuring my comfort.

Yes ☐ No ☐

Pregnancy

If I am pregnant, I wish to receive medical treatment or procedures leading to the safe delivery of my child. Once my child is safely delivered I wish to reinstate my wishes as set out in this form.

Yes ☐ No ☐

Organ donation

I am on the Organ Donor Register

Yes ☐ No ☐

6. Advance Statement

This statement explains why I am making this Advance Decision and what is important to me in relation to my health, care, and quality of life.

I have included additional pages for section 6 and have attached them to this form ☐

7. I would like the following people to be involved in my care

Name: _____

Email: _____

Phone number: _____

Relationship: _____

Name: _____

Email: _____

Phone number: _____

Relationship: _____

8. I have also made a Lasting Power of Attorney for Health and Welfare

The details of my attorney(s) are:

Name: _____

Email: _____

Phone number: _____

Name: _____

Email: _____

Phone number: _____

9. Signature

I confirm that I have carefully considered my wishes as set out in this form and that all the information and decisions within it are my own.

Signature: _____

Name: _____

Date: _____

10. Witness

I confirm that this Advance Decision was signed in my presence.

Signature: _____

Name: _____

Date: _____

Address: _____

Relationship: _____

11. Review dates

I have reviewed this Advance Decision and confirm that what is written reflects my current wishes.

Signed: _____ Date: _____

Signed: _____ Date: _____

Signed: _____ Date: _____

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