

**Advance Decision to Refuse Treatment**

<b>Name (Maker):</b>
<b>Address:</b>
<b>Telephone Number:</b>
<b>Date of Birth:</b>
<b>Any distinguishing feature in the event of unconsciousness (e.g. bald, tattoo):</b>
<b>I make this ‘Advance Decision to Refuse Treatment’ to record my intentions in advance in the event of becoming unable to communicate and having difficulty in participating in decision making in my medical care.</b>
<b>I have made this declaration at a time when I am of sound mind and after careful consideration. I understand that the ‘Advance Decision to Refuse Treatment’ I have given in this form may shorten my life. I accept the risk that I may not be able to change my mind in the future at a time when I am no longer in a position to speak for myself and I have given full consideration to the consequences of the decisions I have made in this document.</b>
<b>I wish to refuse the following treatments:</b>
I would also wish to refuse life sustaining treatment, “even if my life is at risk” such as
Cardio-pulmonary resuscitation (restarting my heart or breathing) <input style="float: right;" type="checkbox"/>
Assisted Ventilation (breathing), including by use of a machine <input style="float: right;" type="checkbox"/>
Artificial nutrition and hydration (giving food or water by any other route than my mouth) <input style="float: right;" type="checkbox"/>
<b>I have marked the boxes to show that these are specific treatments that I do not want. I am aware that I will be provided with basic care, support comfort.</b>
<b>Makers signature</b>
<b>Date</b>
<b>Witness</b>
Name:
Address :

I wish the following person to be consulted and to act as my health care proxy. He / She is aware of my intentions and has a copy of this document:	
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 GP is: (name)		
Address:		
Telephone No:		
Review 1: Date / Time of review	Valid until	
Makers Signature	Witness Signature	
Review 2: Date / Time of review	Valid until	
Makers Signature	Witness Signature	
The following list identifies which people have a copy and have been told about the Advance Decision to Refuse Treatment (and their contact details)		
Name	Relationship	Telephone Number