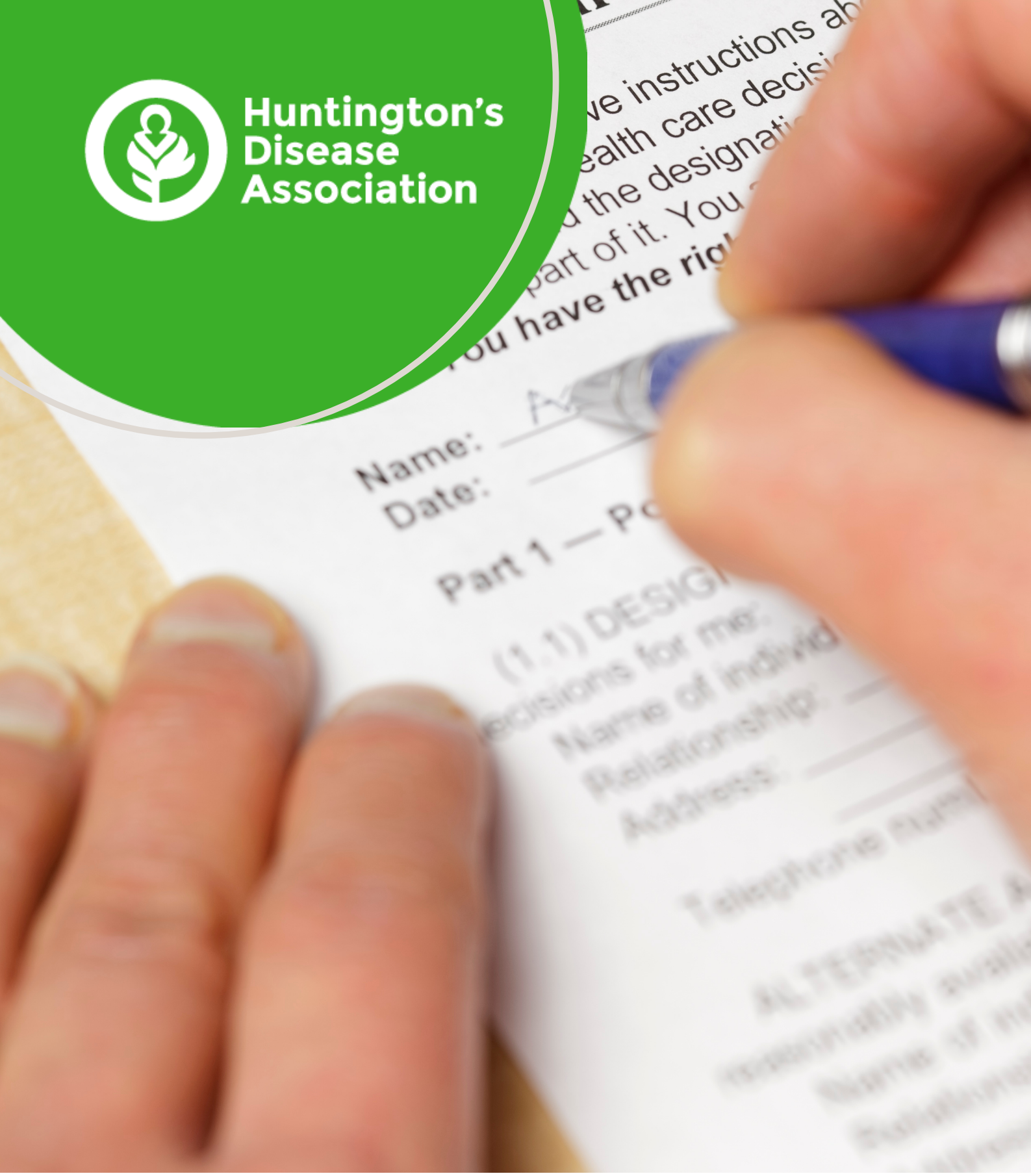
Huntington's Disease Association



Advanced Decision to Refuse Treatment

My personal decision record

This Advance Decision to Refuse Treatment is a written record of my carefully considered health care decisions about the situations in which I want to refuse medical treatment. The decisions within this ADRT should be used in the event that I have lost mental capacity and cannot communicate, consent to or refuse treatment. This Advance Decision replaces any previous Advance Decision I have made.

By completing this Advance Decision to Refuse Treatment (ADRT) I am not refusing my right to receive basic care, support and comfort.

About me

Personal details

Your name: .....

Date of birth: .....

NHS number: .....

Address: .....

.....

Telephone: .....

Distinguishing features in the event of unconsciousness

My advanced decision to refuse treatment

I wish to refuse the following specific treatments If the treatment you want to refuse is life-sustaining*, you must state below that you are refusing it even if your life is at risk as a result.	**In these circumstances**

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

Further information (Optional)

The following information is important to me in relation to my health, care, and quality of life.. It describes my hopes, fears and expectations of life, my potential health and social care problems and explains why I am making this Advance Decision.

Signatures

My 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: .....

Witness

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

Signature: .....

Name: .....

Date: .....

Address: .....

.....

Telephone: .....

Relationship: .....

Review dates (optional)

This Advanced Decision to Refuse Treatment was reviewed and confirmed by me

My signature

Date

My signature

Date

My signature

Date

My signature

Date

My signature

Date

Key contacts

The person to contact to discuss my wishes

Name: .....

Address: .....

.....

Telephone: .....

Relationship: .....

Lasting Power of Attorney for Health and Welfare attorney(s) if relevant

Name: .....

Address: .....

Telephone: .....

Name: .....

Address: .....

.....

Telephone: .....

The Healthcare Professional with whom I have discussed my decisions

Name: .....

Address: .....

.....

Telephone: .....

Profession: .....

Date of discussion: .....

My General Practitioner (G.P)

Name: .....

G.P Practice: .....

Address: .....

.....

Telephone: .....

Now you have completed this document, it is important you store it safely and tell your loved ones where to find it when it is needed.

If you change your mind about anything you have written over time, make sure you update this document to make sure your preferred wishes are carried out.

Get in touch

For advice and support or to speak to a Specialist Huntington's Disease Adviser

email **info@hda.org.uk**
phone **0151 331 5444**

www.hda.org.uk

@hda_tweeting
@hdauk
@hdauk
@hda_uk
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Liverpool Science Park IC1,
131 Mount Pleasant,
Liverpool, L3 5TF

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Inspired by our community