My Advance Decision to Refuse Treatment (ADRT)

1: My details

My personal information	
Name:	**Any distinguishing features if unconscious:**
Address:	**Date of birth:**
	National Health Service (NHS) number:
	Telephone number:

What is this document for?

This document has been completed by me or with my authorisation. It states in advance any treatments I do not want in the future, under specific circumstances. This form replaces any previous ADRT that I have made.

It should only be used if I can no longer refuse or consent to treatment because I have become unable to make or communicate (by any means of communication) decisions about my healthcare.

By completing this document, I understand it is still my right to receive basic care, support and comfort.

Advice to anyone reading my ADRT:

Before any actions are taken, please do not assume I have lost capacity to make decisions about my medical treatment or to communicate them. I may need help and time to make and communicate decisions. I may have to use an alternative method of communication, which may include a communication aid.

If I have lost capacity to make decisions about my medical treatment, please check the validity and applicability of this ADRT. If it is valid and applicable, please ensure that you act on it, as it is a legal document.

Please help to share this information with relevant colleagues involved in my treatment and care, who need to know about this.

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

2: My condition

In relation to my health problems, I have been diagnosed with the following:
This affects me in the following ways:

3: My advance decisions

The following instructions state which treatments I wish to refuse and the precise circumstances in which each action will apply.

Unless stated otherwise below, I confirm that the following decisions to refuse treatment are to apply '**even if my life is at risk as a result**'

(please tick this box if you agree with this statement): ☐

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

4: My signature (please print completed form and sign)

My signature (or nominated person):	**Date of signature:**

5: Witness signatures (please print completed form and sign)

Witness statement: I testify that the maker of this Advance Decision to Refuse Treatment signed it in my presence and made it clear that he/she understood what it meant. I do not know of any pressure being brought on him/her to make such an advance decision and I believe it was made by his/her own wish. As far as I am aware, I do not stand to gain from his/her death.	
First witness	
Name:	**Address:**
Signature:	
Date signed:	**Telephone number:**
Second witness (only one witness is required, but it is preferable to have two)	
Name:	**Address:**
Signature:	
Date signed:	**Telephone number:**

6: Important contacts

If you need to discuss my wishes, the person I would like you to contact first is:	
Name:	Relationship:
Address:	Telephone:
I give permission for this document to be discussed with my relatives/carers: (please tick this box if you agree with this statement): ☐	
I have discussed this document with the following health and social care professional:	
Name:	Profession/Job title:
Contact details:	Date document was discussed:
My General Practitioner (GP) is:	
Name:	Telephone number:
Address:	

These people have a copy of this ADRT or have been told about my advance decisions:		
Name:	**Relationship:**	**Telephone number:**

7: Review dates

I can confirm that the decisions in this document are current and apply unless I specifically state otherwise. I have reviewed this ADRT on the following dates:

Review 1	
My signature	**Date of review**
Review 2	
My signature	**Date of review**
Review 3	
My signature	**Date of review**
Review 4	
My signature	**Date of review**

8: Further information

The following information is important to me, but does not directly relate to my Advance Decision to Refuse Treatment: