My Advance Decision to Refuse Treatment (ADRT)

1: My details

<table>
<tr><th colspan="2">My personal information</th></tr>
<tr><td>Name:</td><td>Any distinguishing features if unconscious:</td></tr>
<tr><td rowspan="3">Address:</td><td>Date of birth:</td></tr>
<tr><td>National Health Service (NHS) number:</td></tr>
<tr><td>Telephone number:</td></tr>
</table>

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 or to communicate. I may need help and time to communicate.

If I have lost capacity, 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**'

(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: (tick one box) Yes: ☐	
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: