# Advance Decision to Refuse Treatment (Living Will)

This document allows you to make a legally binding statement about any medical treatments you do not wish to receive in the future, should you lose the ability to make or communicate decisions for yourself.

It complies with the Mental Capacity Act 2005 and can be used in England and Wales.

## 1. Personal Details

Full Name: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

Date of Birth: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

Address: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]  
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NHS Number: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

GP Name: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

GP Address: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]  
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## 2. Statement of Capacity

I confirm that at the time of making this Advance Decision, I have the mental capacity to make these decisions and understand the implications.

I understand that this Advance Decision will only be used if I am unable to make or communicate decisions myself.

## 3. Life-Sustaining Treatment

I understand that this document relates to life-sustaining treatment and that the refusal of any or all life-sustaining treatment may result in my death.

## 4. My Refusals of Life-Sustaining Treatment

I wish to refuse the following life-sustaining medical treatments, even if it may result in my death:

[ ] Mechanical or artificial Ventilation – this may be used if you cannot breathe by yourself

[ ] Cardiopulmonary resuscitation (CPR) – this may be used if your heart stops

[ ] Artificial nutrition or hydration – feeding or fluids through a tube

[ ] Dialysis – for kidney failure

[ ] Blood transfusion

[ ] Antibiotics – if used to treat infection

[ ] Major Surgery – major interventions under general anaesthetic

[ ] Chemotherapy or radiotherapy – for cancer treatment

[ ] Any other life-sustaining treatment

## 5. Circumstances Where These Refusals Apply

I have ticked any situations where I wish my treatment refusals to apply:

[ ] Advanced dementia – with persistent symptoms or behaviours such as

* Severe memory loss
* Inability to recognize close family
* Inability to understand my environment
* Loss of ability to speak coherently
* Complete dependence on others for basic care
* Evidence of being in considerable pain

[ ] Severe brain injury – with symptoms such as

* Permanent unconsciousness
* Minimal awareness with no communication
* Loss of voluntary movement
* Dependence on life support
* Evidence of being in considerable pain

[ ] Diseases of the central nervous system – with symptoms such as

* Progressive paralysis
* Loss of ability to swallow or breathe unaided
* Inability to communicate
* Loss of bowel and bladder control
* Evidence of being in considerable pain

[ ] Terminal illness – where there is

* No prospect of recovery
* Uncontrolled pain or suffering
* Loss of consciousness
* Complete dependence for all care
* Evidence of being in considerable pain

## 6. To avoid any doubt:

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

## 7. I am making this Advance Decision because:

Here I specify my reasoning behind wanting to refuse life-sustaining treatment(s).

## [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## 8. Signature and Date

Signature: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

Date: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

## 9. Witness Statement

This section must be completed if you are refusing life-sustaining treatment.

I confirm that I am aged 18 or over and that I witnessed the person named above signing this document.

Witness Name: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

Address: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

Signature: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

Date: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

## I have discussed this advanced decision with:

The following is a list of people who I have discussed my Advance Decision with:  
  
[\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

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## Storage and Notification:

People who have a copy of this Advance Decision and/or know where it is stored:  
  
[\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

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## I would like to have following people involved in my care:

I would like the views of the following people taken into account by my healthcare team:   
  
[\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

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## Review Dates:

I may wish to review and update this document over time to demonstrate what I have said in my Advance Decision is still what I choose.

**Review 1**

Signature: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

Date: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

**Review 2**

Signature: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

Date: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

**Review 3**

Signature: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

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Guidance on completion and extra copies can be found at Not So Grave [www.notsograve.co.uk](http://www.notsograve.co.uk)