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Advance decisions (directive) and statement

This is the advance directive of:

Full name:
Address:

I confirm that when making this directive, I am of sound mind with the mental capacity to comprehend the nature and consequences of my decisions and that I have not made it under the influence or harassment of anyone else. My decisions will stand even if life is at risk.

My decisions:

I do not want to receive the following medical treatment:

Please indicate as appropriate.

I refuse medical treatment to prolong my life or keep me alive by artificial means if:

☐ I suffer a severe physical illness from which I am unlikely to recover in the opinion of two independent doctors (one of which is a consultant)

OR

☐ I suffer a severe mental illness which is unlikely to improve and I have a severe physical illness from which I am unlikely to recover, in the opinion of two independent doctors (one of which is a consultant)

OR

☐ I am permanently unconscious and have been so for a period of at least months and from which I am unlikely to recover in the opinion of two independent doctors (one of which is a consultant)

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My decisions:

I wish to receive the following medical treatment:

Please indicate as appropriate.

☐ I wish to receive any medical treatment that will alleviate pain or distressing symptoms or will make me more comfortable. I understand that the result of this treatment may shorten my life.

☐ If I am pregnant and suffering from any of the above conditions, I wish to receive medical treatment which will prolong my life or keep me alive by artificial means only until such time as my child has been safely delivered.

Additional decisions on medical treatment:

Please include any further decisions here.

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General Practitioner (GP)

I have discussed this directive with my GP before signing it. ☐ Yes ☐ No

Please indicate as appropriate.

GP contact information:

Name:	
Address:	
Telephone:	
Signature:	Date:

I have given a copy of this document to the following people:

Please indicate as appropriate below, giving the full name for each.

☐ General Practitioner (GP): . . . . . .

☐ Consultant: . . . . . .

☐ Husband, wife, civil partner, partner: . . . . . .

☐ Other relative: . . . . . .

☐ Friend of long standing: . . . . . .

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Signatures

Signature:	Date:
Print name:	

Witnesses

Your witness should be anyone other than your husband, wife, civil partner, partner, relative or a beneficiary in your will. Two witnesses are required.

I confirm that the above named signed this directive in my presence.

Witness Signature:	Date:
Print name:	

Witness Signature:	Date:
Print name:	