Advance decision

To my family, my GP, my health and welfare attorney (where applicable) and all other persons concerned, this advance decision has been made by me, entirely without influence from any other person, whether they might stand to gain from my death or otherwise.

Full name in capitals:.....
Of [address]:

.....

.....

Date of birth:

.....

I declare that if at any time:

- I am unable to participate effectively in decisions about my medical care **and**
- two independent doctors (one a consultant) are of the opinion that I am unlikely to recover from illness or impairment **and**
- the gravity of my condition/suffering is such that treatment seems to be causing distress beyond any possible benefit,

then in those circumstances my directions are as follows:

- that I am not subjected to any medical intervention or treatment aimed at prolonging or sustaining my life such as those in 'Detailed instruction' below, even if this means my life is at risk. This does not necessarily mean withdrawal of life enhancing medication, as I would not want the withdrawal of any treatment which may reduce distress, provide pain relief or may adversely affect my quality of life
- that any distressing symptoms, including any caused by inability to eat, drink or simply receive nutrition, are to be fully controlled by appropriate analgesic or other treatment, even though that treatment may shorten my life.

Detailed instruction

Insert your personal requests here in relation to the types of medical intervention you would find unacceptable (for example, artificial resuscitation and/or an artificial feeding tube inserted through the stomach wall). Continue on a separate sheet if necessary.

.....

.....

.....

.....

.....

.....

These problems may arise through a dementia related illness (which may or may not have been formally diagnosed) or any other condition of comparable gravity.

I consent to anything proposed to be done or omitted in compliance with the directions expressed above and I absolve my medical attendants from any civil liability arising out of such acts or omissions, provided they take due care in exercising their responsibility.

I reserve the right to revoke this decision at any time, but unless I do so it should be taken to represent my continuing directions.

My health and welfare attorney is/are (cross out if not applicable):

Name:.....

Address: .....

Name:.....

Address: .....
(Continue on a separate sheet if necessary.)

My general practitioner is:

Name:.....

Address: .....

Telephone: .....

Before signing this form I discussed these matters with my GP ☐

Signed: .....

Dated:.....

Witness statement

I testify that the maker of this advance decision signed it in my presence and made it clear to me 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. So far as I am aware I do not stand to gain from his/her death.

Witnessed by:

Signed: .....

Dated:.....

Name:.....

Address: .....

.....

Witnessed by:

Signed: .....

Dated:.....

Name:.....

Address: .....

.....