MY ADVANCE CARE PLAN

(insert photo here)

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Telephone number** |  |
| **Address** | . | **Date of birth** |  |
| **Postcode** |  | **NHS number** |  |
| **Any distinguishing features in the event of unconsciousness** |

**My Advance Care Plan for the end of my life includes:**

* **My Advance Decision to Refuse Treatment** (ADRT). This is legally binding if valid and applicable (please see page 7 and 8 of [Advance-Decisions-to-Refuse-Treatment-Guide.pdf (england.nhs.uk)](https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Advance-Decisions-to-Refuse-Treatment-Guide.pdf))
* **My Advance Statement of Wishes**(ASW) - This gives information about other matters which are important to me. (Although this is not legally binding, the Mental Capacity Act 2006 requires clinical decision makers to give due consideration to this document)

***(When applying this document, please consider the Refusals in the context of the Wishes if there is doubt about applicability or validity)***

# MY ADVANCE DECISION TO REFUSE TREATMENT (ADRT)

#

**I refuse treatments including, but not limited to:**

**I confirm that these refusals of treatments are to apply even if my life is at risk or may be shortened as a result**

**Circumstances in which the refusals apply**

In any situation in which I have been assessed as not having the mental capacity to make the specific decisions required when diagnosed with the following conditions:

**Circumstances in which refusals do not apply**

# MY ADVANCE STATEMENT OF WISHES

# I WOULD LIKE THE FOLLOWING PEOPLE TO BE INVOLVED IN DECISIONS ABOUT MY CARE

I would like the people named below to be consulted when a decision is being made on my behalf. I understand that this does not give them legal decision-making authority unless they also hold Lasting Power of Attorney for Health and Welfare that is valid and applicable for the specific decision to be made.I give my consent for them to be contacted by telephone, email, Skype/Zoom (or similar).

I would like it to be made clear to them that, whilst I wish them to be consulted when possible, they do not bear final responsibility for decisions about accepting or refusing interventions (unless they also hold Lasting Power of Attorney for Health and Welfare that is valid and applicable for the specific decision to be made). I would like ………………………………………….. to be contacted in the first instance.

|  |
| --- |
| **Name** |
| **DOB** |  | **Relationship** |  |
| **Address** |  | **Telephone number** |  |
| **Postcode** |  | **Email address** |  |

|  |
| --- |
| **Name** |
| **DOB** |  | **Relationship** |  |
| **Address** |  | **Telephone number** |  |
| **Postcode** |  | **Email address** |  |

|  |
| --- |
| **Name** |
| **DOB** |  | **Relationship** |  |
| **Address** |  | **Telephone number** |  |
| **Postcode** |  | **Email address** |  |

# MY DECLARATION AND SIGNATURE

The decisions and preferences set out reflect my wishes. They have been made at a time when I have mental capacity and I can make them. These decisions are my own and have not been made under the influence of other people.

|  |  |
| --- | --- |
| **Name** |  |
| **Signature** |
| **Date** |  |

**WITNESS**

I confirm this Advance Decision to Refuse Treatment was signed in my presence.

|  |
| --- |
| **Signature** |
| **Name** |  | **Date** |  |
| **Address** |  | **Postcode** |  |
| **Telephone number** |  | **Email address** |  |

# GP DETAILS and DECLARATION *(this is not a legal requirement but may make the document more effective in practice)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Telephone number** | . |
| **Address** |  | **Postcode** |  |
| **Declaration***I have discussed the matters contained in this document with …….and I am satisfied that they have the capacity to make and understand the decisions in it.***Signature****Date** |