Section 7: Details of people who have a copy and have been told about this Advance Decision to Refuse Treatment

Name	Relationship to you	Telephone

Section 8: Further information (optional)

I have written the following information that is important to me. It describes my hopes, fears and expectations of life and any potential health and social care problems. It does not directly affect my Advance Decision to Refuse Treatment but the reader may find it useful.

ADRT adaption This form has been adapted, with permission, from the National End of Life Care Programme's Advance Decisions to Refuse Treatment proforma, which was originally published in September 2008.

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MAC13616_0115_Form1

My Advance Decision to Refuse Treatment Document

WE ARE MACMILLAN. CANCER SUPPORT

About this document

This document is for you to write down in advance any specific treatments that you don't want to have in the future. It will only be used if you lose the mental capacity to make decisions for yourself about your healthcare needs and are therefore unable to consent to or refuse treatment.

You must ensure that this Advance Decision to Refuse Treatment (ADRT) is up to date and replaces any previous decisions you have made.

By completing this Advance Decision to Refuse Treatment (ADRT) you are not refusing your right to receive basic care, support and comfort.

Section 1: My details

Name	Any distinguishing features in the event of unconsciousness
Address	
Date of birth	Telephone number

Section 2: My Advance Decision to Refuse Treatment

I wish to refuse the following specific treatments *If you wish to refuse a treatment that is or may be life-sustaining, you must state in the box: 'I am refusing this treatment even if my life is at risk as a result.'	In these circumstances

An Advance Decision refusing life-sustaining treatment must be signed by you (or by another person in your presence and by your direction) and witnessed by someone else.

Section 3: My signature and witnesses

My signature (or nominated person directed by me to sign) signed in the presence of my witness

Date of signature

Witness name

Witness signature (signed in my presence)

Witness address

Date of signature

Witness telephone number

Section 4: Person to be contacted to discuss my wishes (optional)

Name

Relationship to you

Address

Telephone number

Section 5: Details of healthcare professionals

I have discussed this Advance Decision to Refuse Treatment with (eg name of healthcare professional)

Profession/Job title

Contact details

Date

I give permission for this document to be discussed with my relatives/carers

Yes No

(please circle one and specify if you only wish for it to be discussed with specific people)

My general practitioner (GP) is

Telephone number

Address

Section 6: Optional review dates – this Advance Decision to Refuse Treatment was reviewed and confirmed by me

Signed	Date
Signed	Date
Signed	Date
Signed	Date