Advance Directive (Living Will) –
Form for patients

The Practice wishes to assure you and your carers, that under all circumstances it will strive to provide what is considered to be the best treatment for you.

This form is designed for you to record aspects of treatment that you do not wish to have under specified circumstances.

If you choose not to tick any of the boxes in Section 2, your doctor will continue to provide you with any active treatment(s) he/she feels reasonable in the specified circumstances, in consultation with your next of kin or the proxy you have nominated.

PLEASE NOTE: This Living Will is about medical treatment only. You cannot use it to say what is to happen after your death, or to make funeral arrangements, or to dispose of property after your death.

1. Statement of Beliefs

If you wish to do so, please record a statement of your beliefs and values below - there is no legal requirement to complete this section.

2. General Medical Treatment

There are three possible health conditions described below. Within each of the three you can tick the box provided to indicate your advance refusal of treatment in these circumstances.

Please ensure you treat each condition separately, and it is important to note that you do not have to make the same choice for one.

I (insert your name) ……
DECLARE that my medical treatment wishes are as follows:

Life Threatening Condition:
If I have a physical illness from which there is no likelihood of recovery AND it is so serious that my life is nearing its end:

☐ I do not wish to be kept alive by medical treatment. I wish medical treatment to be limited to keeping me comfortable and free from pain, and I refuse all other medical treatment.

Permanent Mental Impairment:
If my mental functions become permanently impaired with no likelihood of improvement, the impairment is so severe that I do not understand what is happening to me and my physical condition means that medical treatment would be needed to keep me alive:

☐ I do not wish to be kept alive by medical treatment. I wish medical treatment to be limited to keeping me comfortable and free from pain and, I refuse all other medical treatment.

Persistent Unconsciousness:
If I become persistently unconscious with no likelihood of regaining consciousness:

☐ I do not wish to be kept alive by medical treatment. I wish medical treatment to be limited to keeping me comfortable and free from pain, and I refuse all other medical treatment.

3. Particular treatments or investigations

If you have any wishes about a particular medical treatment or test, you can record them here. If you wish to refuse a particular treatment or investigation, you should say so clearly. You should consult a doctor before writing anything in the space provided.

I have the following wishes about particular medical treatment or tests:

4. Presence of a relative or friend

You can complete this section if you would like a particular person to be with you if your life is in danger. Please note, however, that it may not be possible to contact the person you name, or for him/her to arrive in time.

If my life is in danger I wish the following person to be contacted to give him/her the chance to be with me before I die.

Name:	
Address:	
Contact phone number(s)	

	Tick this box if you would like those caring for you to do their best to keep you alive for as long as is reasonable, in order to give the person you have named above a chance to see you. This instruction might mean that the doctors would need to temporarily disregard your choices in Section 2 of this form and also any refusal of particular treatment or test.

Health Care Proxy

I appoint the following person as my Health Care Proxy:

Name:	
Address:	
Contact Phone Number(s):	

Statement by Proxy :

I (Name) ……
Agree to act as health care proxy for

(Name) …….

If she/he becomes unable to make their own wishes known.

- I understand that I will be consulted as far as possible, when decisions about tests or treatments need to be made.

- I understand that my role as proxy is to inform the health care team of what I know of ……’s beliefs or wishes about their future care, so that these beliefs and wishes can be taken into account when the health care team make their decisions about him/her.

- I understand that I cannot insist on any treatment which the health care team do not feel would be in ……..’s best interests.

Signed: ……Date: ……

Living Will (Advance Refusal of Treatment)

Declaration

This is an important document.

NPMC recommends that you discuss your Living Will with a doctor, but you do not have to.

Personal details

I (Name) ……..

Of (Address)……

…….

Make this Living Will to state my wishes in case I become unable to communicate, and cannot take part in decisions about my medical care.

If you consult a doctor about this Living Will, please complete this section

I have discussed this Living Will with the following doctor.

Doctors Name …….

Contact Address……..

……

Contact Telephone Number……

Signatures

My Signature:	Date:
The witness must sign after you have signed and should then print his/her name and address in the space provided. **IN THE PRESENCE OF**	
Signature Of Witness:	Date:

Name of Witness:
Address:

This document remains effective until I make it clear that my wishes have changed