Living Will UK

Advance Decision to Refuse Treatment | Mental Capacity Act 2005, Sections 24–26

This document is designed to record your wishes about medical treatment in advance. It enables you to refuse specific treatments in specified circumstances should you become unable to communicate or take part in decisions about your medical care.

If you choose not to select any of the refusal options in Section 2, your treating clinician will continue to provide any treatment they consider to be in your best interests, in consultation with your next of kin or the healthcare proxy you have nominated.

PLEASE NOTE: This Living Will relates to medical treatment only. It cannot be used to say what is to happen after your death, to make funeral arrangements, or to dispose of property after your death.

1. STATEMENT OF BELIEFS

You may use the space below to record a statement of your personal beliefs and values. This section is entirely optional — there is no legal requirement to complete it.

2. GENERAL MEDICAL TREATMENT

Three clinical circumstances are described below. Within each you may indicate an advance refusal of life-sustaining treatment by selecting the option provided. Each condition must be treated separately; you are not required to make the same choice for each.

I _____

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, even if my life is at risk as a result of that refusal.

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;
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, even if my life is at risk as a result of that refusal.

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, even if my life is at risk as a result of that refusal.

3. PARTICULAR TREATMENTS OR INVESTIGATIONS

If you have any specific wishes about a particular medical treatment or diagnostic investigation, you may record them below. If you wish to refuse a specific treatment or investigation, you should state this clearly. It is advisable to consult a doctor before completing this section.

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

4. PRESENCE OF RELATIVE OR FRIEND

You may complete this section if you would like a particular person to be with you should your life be in danger. Please note that it may not always be possible to contact the person you name, or for them to arrive in time.

If my life is in danger, I wish the following person to be contacted to give them the opportunity to be with me before I die.

Name: _____

Address: _____

_____

Contact Telephone Number(s): _____

☐ Tick this box if you wish those caring for you to do their best to keep you alive for as long as is reasonable, in order to give the person named above a chance to be with you.

Please note: this instruction may require clinicians to temporarily disregard your choices in Section 2 and any refusal of particular treatment or investigation in Section 3.

HEALTH CARE PROXY

I appoint the following person as my Health Care Proxy:

Name: (Mr / Mrs / Miss / Mx) _____

Address: _____

_____

Contact Telephone Number(s): _____

Statement by Proxy:

I _____

agree to act as Health Care Proxy for

_____

if they become unable to make their own wishes known.

- I understand that I will be consulted, as far as is reasonably practicable, when decisions about tests or treatments need to be made.
- I understand that my role as proxy is to inform the healthcare team of what I know of the above-named person's beliefs and wishes about their future care, so that these may be taken into account when the healthcare team makes its decisions.
- I understand that I cannot insist on any treatment which the healthcare team does not consider to be in the above-named person's best interests.

Signed: _____ Date: _____

Living Will (Advance Decision to Refuse Treatment)

Declaration

This is an important document.

It is strongly recommended that you discuss this Living Will with your General Practitioner. You are not legally required to do so, but doing so helps to ensure that your wishes are understood, properly recorded, and accessible to treating clinicians when needed.

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.

Doctor's Name: _____

Contact Address: _____

_____

Contact Telephone Number: _____

SIGNATURES

My Signature: _____ **Date:** _____

The witness must sign after you have signed and should then print their 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 clear that my wishes have changed.