ADVANCE DECISION TO ALLOW A NATURAL DEATH

Name (Maker): Address:	Telephone Number: DOB: Date completed: NHS No:

Any distinguishing features in the event of unconsciousness:

Healthcare professional involved in Advance Care Planning discussions

Name and Role: Telephone:
Address: Date:
Signature:

I have freely and in sound mind made these advance decisions about my health care, in the event that I cannot consent to treatment. These replace any previous decisions I have made.

In these specific circumstances *(e.g. advanced terminal malignancy)*:

I wish to refuse the following treatments *(e.g. blood transfusion, antibiotics)*:

I would also wish to refuse life sustaining treatment "even if my life is at risk" such as:

Cardio-Pulmonary Resuscitation (re-starting my heart or breathing) …… ☐

Assisted Ventilation (breathing), including by use of a machine ……. ☐

Clinically Assisted Nutrition and Hydration (giving food or water by any ……. other route than by my mouth) ☐

I have put my signature in the relevant boxes above to show that these are specific treatments I do not want. I am aware that I will be provided basic care, support and comfort. I consent to the use of painkillers and other measures to control distressing symptoms regardless of the consequences for my physical health.

Preferred Place of Care
If your condition deteriorates where would you most like to be cared for? (e.g. home or hospital)
1st Choice: **2nd Choice:**

Document collated by Roni Ross after consultation with GPs and other co-workers within Bath and North East Somerset NHS Trust.

Person to be contacted to discuss my wishes:

Name: Relationship:
Address: Telephone:

Lasting power of attorney? YES NO (*circle as appropriate)*

My **General Practitioner** is: …… Telephone Number:
Surgery name and address:

General Practitioner's Signature: …… Date: ……..

The following list identifies which people have a copy and have been told about this 'Advance Decision to Refuse Treatment'.

Name	Relationship	Telephone	Address

Please send Great Western Ambulance Service a copy of this form, by faxing to: 0845-1294340.

This document is valid until further notice, or if specified, until the review date below.

Date of review: ……

Maker's Signature: …… **Date of Signature:** …….……

Witness Signature: …….. **Witness Name:** ……

Witness address: …….……

Witness occupation / relationship (if any) to Maker: ……..

Date of witness signature: ……..

THE END.

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