

Advance decisions (directive) and statement

This is the advance directive of:

Full name:
Address:

I confirm that when making this directive, I am of sound mind with the mental capacity to comprehend the nature and consequences of my decisions and that I have not made it under the influence or harassment of anyone else. My decisions will stand even if life is at risk.

My decisions:

I do not want to receive the following medical treatment:

Please indicate as appropriate.

I refuse medical treatment to prolong my life or keep me alive by artificial means if:

I suffer a severe physical illness from which I am unlikely to recover in the opinion of two independent doctors (one of which is a consultant)

OR

I suffer a severe mental illness which is unlikely to improve and I have a severe physical illness from which I am unlikely to recover, in the opinion of two independent doctors (one of which is a consultant)

OR

I am permanently unconscious and have been so for a period of at least months and from which I am unlikely to recover in the opinion of two independent doctors (one of which is a consultant)

General Practitioner (GP)

I have discussed this directive with my GP before signing it. Yes No

Please indicate as appropriate.

GP contact information:

Name:	
Address:	
Telephone:	
Signature:	Date:

I have given a copy of this document to the following people:

Please indicate as appropriate below, giving the full name for each.

- General Practitioner (GP):
- Consultant:
- Husband, wife, civil partner, partner:
- Other relative:
- Friend of long standing:

Signatures

Signature:	Date:
Print name:	

Witnesses

Your witness should be anyone other than your husband, wife, civil partner, partner, relative or a beneficiary in your will. Two witnesses are required.

I confirm that the above named signed this directive in my presence.

Witness Signature:	Date:
Print name:	

Witness Signature:	Date:
Print name:	