Cheshire West & Chester Council

My Advance Decision to Refuse Treatment

Name

Address

Any distinguishing features in the event of unconsciousness

Date of Birth

Telephone Number

What is this document is for?

This advance decision to refuse treatment has been written by me to specify in advance which treatments I don't want in the future. These are my decisions about my healthcare, in the event that I have lost mental capacity and cannot consent to or refuse treatment. This advance decision replaces any previous advance decision I have made.

Advice to the reader

I have written this document to identify my advance decision. I would expect any health care professionals reading this document in the event I have lost capacity to check that my advance decision is valid and applicable within the meaning of the Mental Capacity Act 2005, in the circumstances that exist at the time.

Please Check

Please do not assume I have lost capacity before any actions are taken. I might need help and time to communicate.

If I have lost capacity please confirm the validity and applicability of this advance decision.

This advance decision becomes legally binding and must be followed if professionals are satisfied it is valid and applicable and meets the requirements of the Mental Capacity Act 2005. Please help to share this information with people who are involved in my treatment and care and need to know about this.

Please also check if I have made any other statements about my preferences or decisions that might be relevant to my advance decision.

This advance decision does not refuse the offer and or provision of basic care, support and comfort.

My Name

My advance decision to refuse treatment

I wish to refuse the following specific treatments:	In these circumstances:

(Note to the person making this statement: If you wish to refuse a treatment that is or may be life-sustaining, you must state in the box above that you are refusing that treatment even if you life is at risk as a result. An advance decision refusing life-sustaining treatment must be signed and witnessed).

My Signature | Date

Witness Name

Address | Telephone Number

Witness Signature | Date

Person to be contacted to discuss my wishes:

Name

Address | Telephone Number | Relationship

I have discussed this 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

My General Practitioner is:

Name

Address | Telephone Number

Optional Review:

Date | Time

Comment

Makers Signature	
Witness Signature	

The following list identifies which people have a copy and have been told about this Advance Decision to Refuse Treatment (and their contact details)

Name	Relationship	Telephone Number

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 might find it useful.

Accessing Cheshire West and Chester Council information and services

Council information is also available in Audio, Braille and Large Print formats. If you would like a copy in any of these formats or in another language, please email us at **equalities@cheshirewestandchester.gov.uk**
We are also able to provide a British Sign Language (BSL) interpreter to support customers with accessing Council services.

Tel: 0300 123 8 123 **Textphone**: 01606 867 670
email: equalities@cheshirewestandchester.gov.uk
web: www.cheshirewestandchester.gov.uk

NHS

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