

**ADVANCE DECISION TO REFUSE TREATMENT**

**Form B**

**Important note for health and social professionals**

Any health or social care professional reading this decision to refuse treatment must check that it is valid and applies in the circumstances at the time.

This decision to refuse treatment becomes legally binding and must be followed if professionals are satisfied that it is valid and applies in the circumstances at the time. However, you should not immediately assume that the patient cannot make their own decisions. They might just need help and time to communicate.

You should share this information with everyone who is involved in the patient’s treatment and care.

This decision to refuse treatment does not prevent health or social care professionals offering or providing basic care support and comfort.

**Part 1 – Seeking advice**

Before you make your decision it is recommended that you get advice from the health care professional most closely involved in your care or an organisation that can provide advice in relation to your specific condition or situation. This will help you to have all the information you need to make an informed decision.

Who have you talked to about your decision to refuse treatment?

(Please tick all appropriate boxes)

|  |  |  |
| --- | --- | --- |
| **GP** |  | Name: |
| **Nurse** |  | Name: |
| **Consultant** |  | Name: |
| **Key Worker** |  | Name:Position: |
| **Other** |  | Name:Position |

**Part 2 - My details**

|  |  |
| --- | --- |
| **Name**  |  |
| **Date of birth** |  |
| **NHS number (or other identifier)** |  |
| **Address and postcode** |  |
| **Phone** |  |
| **Email address**  |  |

**Part 3 - My decisions**

I do not want to receive the specific treatments shown below**. My directions apply even if my life is at risk as a result.**

|  |  |
| --- | --- |
| **Specific treatment I want to refuse** | **Circumstances I want to refuse the treatment in** |
|  |  |
|  |  |
|  |  |
|  |  |

**Part 4 - My declaration and signature**

**Declaration- to my family, my doctor and everyone else concerned:**

I am making this decision to refuse treatment voluntarily and am mentally capable of doing so. I am fully aware of the potential consequences of refusing treatment, **even if my life is at risk as a result**.

I can understand, weigh up and remember all the information relevant to this decision to refuse treatment and can explain my decision.

If I become unable to make decisions about my medical care, my instructions are set out in Form B (Part 3), unless amended by any change shown in form B (Part 6)

I understand that this decision to refuse treatment does not prevent health or social care professionals offering or providing basic care, support and comfort.

I understand that I can cancel this decision to refuse treatment at any time.

|  |  |
| --- | --- |
| **Signature**  | **Date**  |
|  |  |

**Part 5 - Witness declaration**

The person making this decision to refuse treatment signed it voluntary and in front of me.

|  |  |
| --- | --- |
| **Witness Name**  |  |
| **Witness Signature**  | **Date** |
|  |  |

|  |  |
| --- | --- |
| **Address and postcode** |  |
| **Contact number**  |  |
| **Email address**  |  |
| **Relationship to the person making the decision**: |  |

**It may be helpful to give copies of this form to health and social care professionals who are involved in your care.** If you are in hospital or a hospice, you should tell the consultant or most senior doctor caring for you about this decision to refuse treatment

**Part 6 – Changes to your wishes**

You should regularly review this decision to make sure it still represents your wishes. In the following box you should make a note of any changes you want to make. Each change must be signed and witnesses and you must give your signature and the date. Make sure your GP, key worker, and any other relevant people (for example, your family, friends and any other health and social care professionals) are told about any changes. Also, if you change any of your decisions on your original documents, you must remember to also change any copies that are held elsewhere.

|  |
| --- |
| **Details of changes made**  |
|  |
| **Signature**  | **Date**  |
|  |  |

|  |  |
| --- | --- |
| **Witness`s Name**  |  |
| **Witness`s Signature**  | **Date** |
|  |  |
| **Address and Post code** |  |
| **Contact number**  |  |
| **Email Address**  |  |
| **Relationship to the person making the decision**  |  |

|  |
| --- |
| **Details of changes made**  |
|  |
| **Signature**  | **Date**  |
|  |  |

|  |  |
| --- | --- |
| **Witness`s Name**  |  |
| **Witness`s Signature** | **Date** |
|  |  |
| **Address and Post code** |  |
| **Contact number**  |  |
| **Email Address**  |  |
| **Relationship to the person making the decision**  |  |

**Part 7 – Letting people know your wishes**

It is important to let your family, carers and any professional involved in your health and social know about your choices and where to find your original document. Your family or cares may have to find it quickly if you require emergency treatment and they need tell health professional your wishes when you are unable to do so yourself, so remember to keep the original copy safe.

|  |  |  |
| --- | --- | --- |
| **Name**  | **Relationship to you**  | **Contact details**  |
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| **Any Additional Information**  |
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