Advance decision to refuse treatment (ADRT)

v8 (Adapted from *Advance Decisions to Refuse Treatment: a Guide for Health and Social Care Staff*, 2008)

My name	If I became unconscious, these are distinguishing features that could identify me:
Maire Sammhradh	Large mole on my left upper arm
Address 5 Ceilidh Side, Loch Gairloch,GA25 3PQ	**Date of birth:** 01-Jan-1940 **NHS no (if known):** 123 456 789 **Hospital no (if known):** 012345X
	Telephone Number 0123 456 789

What is this document 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 decision I have made.

Advice to the carer reading this document: Please check

- **Please do not assume that I have lost mental capacity before any actions are taken.** I might need help and time to communicate when the time comes to need to make a decision.
- If I have lost mental capacity for a particular decision **check that my advance decision is valid, and applicable to the circumstances that exist at the time.**
- **If the professionals are satisfied that this advance decision is valid and applicable this decision becomes legally binding and must be followed**, including checking that it is has not been varied or revoked by me either verbally or in writing since it was made.
  Please share this information with people who are involved in my treatment and need to know about it.
- Please also check if I have made an advance statement about my preferences, wishes, beliefs, values and feeling that might be relevant to this advance decision.

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

Important note to the person making this advance decision:

If you wish to refuse a treatment that is (or may be) life-sustaining you must state in the boxes ***"I am refusing this treatment even if my life is at risk as a result."***
Any advance decision that states that you are refusing life-sustaining treatment **must be signed and witnessed on page 3.**

My name	Maire Sammhradh	**NHS no (if known)** 123 456 789

My advance decision to refuse treatment

I wish to refuse the following specific treatments:	**In these circumstances:**
Ventilation requiring admission to intensive care I am refusing this treatment even if my life is at risk as a result	Respiratory failure due to untreatable lung infection
Renal dialysis I am refusing this treatment even if my life is at risk as a result	Renal failure secondary to treatment with diuretics
Cardiopulmonary resuscitation I am refusing this treatment even if my life is at risk as a result	Myocardial infarction (heart attack) Severe heart failure Respiratory failure
Artificial hydration and feeding I am refusing this treatment even if my life is at risk as a result	Irreversible brain damage Multi-organ failure

My signature (or nominated person)	Date of signature 01-Sep-2018

My name	Maire Sammhradh	NHS no (if known) 123 456 789

Witness:	
Witness signature	Name of witness Maclolm Sammhradh
Address of witness same address	Telephone of witness S/A Date 01-Sep-2018

Person to be contacted to discuss my wishes:	
Name Malcolm Sammhradh	Relationship Husband
Address S/A	Telephone Same

I have discussed this with (eg. name of healthcare professional)

Profession / Job title: My consultant, Dr. Achmelvich Date:

Contact details: Inverness Hospital, Tel: 0456 789 1234

I give permission for this document to be discussed with my relatives / carers

Yes ☑ **No** ☐ (please select one)

My general practitioner is:

Name: Dr. Lochinver Telephone: 0789 456 1234

Address: The Surgery, Ullapool

Optional review

Comment Date/time:

Signature of person named on page 1:

Witness signature:

My name	Maire Sammhradh	NHS no (if known) 123 456 789

The following list identifies which people have a copy and have been told about this advance decision to refuse treatment (ADRT)

Name	Relationships	Telephone number
Myra Torridon	Hospital nurse	0456 789 1234
Angus Trossachs	Hospital doctor	0456 789 1234
Nina O'Sullibhan	Macmillan nurse	0789 123 456
Lyra Scott	Daughter	0123 456 789

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 may find it useful, for example to inform any clinical assessment if it becomes necessary to decide what is in my best interests.

I understand that my heart and chest problems will shorten my life and have discussed what will happen with my family, doctors and nurses. This is not to say that I want to die now, because I still enjoy being with my family, my music and watching Coronation Street on the box. So if treatment is possible and can get me back home I would agree to this, but I do not wish to be kept alive when I cannot recover fully or if I have developed brain damage that cannot get better. I would then wish to be allowed to die peacefully with whatever drugs and care are needed to keep me comfortable.