Advance Decision of (YOUR NAME)

I, (YOUR NAME), of (YOUR ADDRESS), being of sound mind and over the age of 18 years, make this Advance Decision fully understanding the consequences of my action in doing so. I intend this Advance Decision to be read by my health care providers, family and friends as a true reflection of my wishes and instructions should I become incapacitated and unable to communicate such wishes and instructions.

## DEFINITIONS

As used in this document:

* 1. "Health Care Provider" means any person licensed, certified or otherwise authorised by law to administer health care in the ordinary course of business or practice of a profession.
	2. "Terminal Condition" means a condition caused by injury, disease or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.
	3. "Persistently Unconscious" means being in a profound state of unconsciousness caused by disease, injury, poison or other means from which there exists no reasonable expectation of regaining consciousness.
	4. "Severely and Permanently Mentally Impaired" means being in a permanent and irreversible state of mental impairment in which there is:
		1. The absence of voluntary action or cognitive behaviour; and
		2. An inability to communicate or interact purposefully with the environment.
	5. "Life Support" means any medical procedure, treatment or intervention which sustains, restores or supplants a spontaneous vital function. In this document the term does not include tube feeding or the provision of medication or the performance of a medical procedure when such medication or procedure is deemed necessary to provide Comfort Care or to alleviate pain.
	6. "Tube Feeding" means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).
	7. "Cardiopulmonary Resuscitation" means restoration of heartbeat and breathing following cardiac arrest, using artificial respiration and external cardiac massage.
	8. "Comfort Care" means treatment, including prescription medication, provided to the patient for the sole purpose of alleviating pain and discomfort.

## STATEMENT OF VALUES AND BELIEFS

* 1. My fundamental beliefs are that a person should be allowed to die with grace and dignity and that a life should not be prolonged with aggressive medical treatment where the resulting quality of life is poor and where there is no reasonable expectation of recovery. I am categorically against being given a vaccine (a substance used to stimulate the production of antibodies and provide immunity

against one or several diseases, prepared from the causative agent of a disease, its products, or a synthetic substitute, treated to act as an antigen without inducing the disease) of any kind.

## TREATMENT DIRECTIONS AND END-OF-LIFE DECISIONS

I direct that my health care providers and others involved in my care provide, withhold or withdraw treatment in accordance with my directions below:

* 1. If I have an incurable and irreversible Terminal Condition that will result in my death within a relatively short time, I direct that:
		1. I not be given Life Support or other life-prolonging treatment;
		2. I not receive Tube Feeding even if withholding such feeding would hasten my death;
		3. I not receive Cardiopulmonary Resuscitation in the event of cardiac arrest; and
		4. Should I develop another separate condition that threatens my life, such other illness not be given active treatment unless it appears to be causing me undue suffering.
	2. If I am diagnosed as Persistently Unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, I direct that:
		1. I not be given Life Support or other life-prolonging treatment;
		2. I not receive Tube Feeding even if withholding such feeding would hasten my death;
		3. I not receive Cardiopulmonary Resuscitation in the event of cardiac arrest; and
		4. Should I develop another separate condition that threatens my life, such other illness not be given active treatment unless it appears to be causing me undue suffering.
	3. If I am diagnosed as being Severely and Permanently Mentally Impaired, I direct that:
		1. I not be given Life Support or other life-prolonging treatment;
		2. I not receive Tube Feeding even if withholding such feeding would hasten my death;
		3. I not receive Cardiopulmonary Resuscitation in the event of cardiac arrest; and
		4. Should I develop another separate condition that threatens my life, such other illness not be given active treatment unless it appears to be causing me undue suffering.
	4. If I should be in any of the above-mentioned conditions and if my behaviour is violent or otherwise degrading, I want my symptoms to be controlled with

appropriate drugs, even if that would worsen my physical condition or shorten my life.

* 1. If I should be in any of the above mentioned conditions and I appear to be in pain, I want my symptoms to be controlled with appropriate drugs, even if that would worsen my physical condition or shorten my life.

## ORGAN DONATION

* 1. I do not, under any circumstances want my organs or tissue to be used for transplantation upon my death.

## GENERAL

* 1. I understand that I may revoke this Advance Decision at any time either orally or in writing when I have capacity to do so.
	2. A copy of this Advance Decision has the same effect as the original.
	3. If any part or parts of this Advance Decision is found to be invalid or illegal under applicable law by a court of competent jurisdiction, the invalidity or illegality of such part or parts shall not in any way affect the remaining parts and this document shall be construed as though the invalid or illegal part or parts had never been included herein. But if the intent of this Advance Decision would be substantially changed by such construction, then it shall not be so construed.
	4. This Advance Decision is intended to be governed by the laws of England.

## SIGNATURE

Signed at (YOUR ADDRESS), this (DATE).

(YOUR NAME)

(YOUR ADDRESS)

(YOUR DOB)

(DATE)

## STATEMENT OF WITNESS

I declare that: (WITNESS NAME)

1. The individual who signed or acknowledged this Advance Decision, (YOUR NAME), is personally known to me or her identity was proven to me by convincing evidence;
2. (YOUR NAME) appeared to be eighteen (18) years of age or older;
3. I am of at least eighteen (18) years of age and (YOUR NAME) signed or acknowledged this Advance Decision in my presence;
4. (YOUR NAME) appears to be of sound mind and under no duress, fraud, or undue influence;
5. I am not (YOUR NAME) health care provider, an employee of (YOUR NAME) health care provider or the operator or employee of a nursing home or other

residence for the elderly or handicapped in which (YOUR NAME) is a resident; and

1. I am not related to (YOUR NAME) by blood or marriage and I would not be entitled to

any portion of (YOUR NAME) estate on her death.

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| --- |
| Witness: #1 |
| Signature |
| Print Name |
| Address |
| City, County |
| Date |

RECORD OF COPIES

Record of people and institutions to whom I have given a copy of this Advance Decision:

|  |  |  |
| --- | --- | --- |
| 1. | (USUALLY PARTNER) | Date |
| 2. | (USUALLY PARENT) | Date |
| 3. | (USUALLY HEALTH PROFESSIONAL) | Date |