Advance decision to refuse treatment (ADRT)

My name	If I become unconscious, these are the distinguishing features that could identify me:
Address	Date of birth: NHS no (if known): Hospital no (if known):
	Telephone number:

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 future.

These are my decisions about my healthcare, **in the event that I have lost mental capacity and cannot consent to 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	

My advance decision to refuse treatment

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

My signature (or nominated person)	Date of signature

Witness:	
Witness signature	Name of witness
Address of witness	Telephone of witness Date

Person to be contacted to discuss my wishes:	
Name	Relationship
Address	Telephone

I have discussed this with (eg. name of healthcare professional)	
Profession / Job title:	Date:
Contact details:	

I give permission for this document to be discussed with my relatives / carers
☐ Yes ☐ No (please tick one)

Optional review	
Comment	Date/time:
Signature of person named on page 1:	Witness signature:

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

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.

Original source:
Advance Decisions to Refuse Treatment: a Guide for Health and Social Care Staff (2008).
Adapted by the North East Deciding right programme with permission from National End of Life Care Programme.