LEGAL DISCLAIMER

This document template is provided for informational purposes only and does not constitute legal or medical advice. This template is provided "as is" without warranty of any kind. Healthcare and mental capacity law varies by jurisdiction and changes over time.

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• For a Living Will to be legally binding in England and Wales, it must comply with the Mental Capacity Act 2005

• Refusals of life-sustaining treatment must be in writing, signed, and witnessed

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ADVANCE DECISION TO REFUSE TREATMENT (LIVING WILL)

IMPORTANT NOTICE

This is a legal document that allows you to refuse specific medical treatments if you lose the capacity to make or communicate decisions about your care. It will only be used if you lose the capacity to make or communicate decisions about your treatment.

PERSONAL DETAILS

Full Name: **[FULL NAME]**

Address: **[ADDRESS]**

Date of Birth: **[DATE OF BIRTH]**

NHS Number (if known): **[NHS NUMBER]**

STATEMENT OF CAPACITY

I, **[FULL NAME]**, make this Advance Decision to Refuse Treatment of my own free will. I am over 18 years of age and have the mental capacity to make the decisions contained in this document. I understand the nature, purpose, and consequences of refusing the specified treatments, including that some refusals may result in my death. I wish this Advance Decision to be legally binding and to be respected by all those responsible for my care.

WHEN THIS ADVANCE DECISION APPLIES

This Advance Decision applies only in circumstances where I lack the capacity to consent to or refuse the treatments specified in this document, and where I am suffering from the conditions specified below.

This Advance Decision applies in the United Kingdom and, as far as is legally possible, anywhere else I may be at the time treatment decisions need to be made.

This Advance Decision remains in force unless and until it is revoked by me while I have the capacity to do so.

GENERAL VALUES AND PREFERENCES

The following statements express my values, beliefs, and preferences. While they are not legally binding refusals of treatment, I would like them to be taken into account by anyone making decisions about my care if I lack capacity:

[PERSONAL VALUES AND BELIEFS RELEVANT TO MEDICAL DECISIONS]

[QUALITY OF LIFE CONSIDERATIONS]

[RELIGIOUS OR CULTURAL CONSIDERATIONS]

[GENERAL CARE PREFERENCES]

[COMFORT AND PAIN MANAGEMENT PREFERENCES]

SPECIFIC TREATMENT REFUSALS

I refuse the following specific treatments in the circumstances specified:

Cardiopulmonary Resuscitation (CPR)

I refuse CPR in the following circumstances:

- **[SPECIFY CIRCUMSTANCES, e.g., "If I am suffering from an advanced terminal illness with no prospect of recovery"]**

- **[SPECIFY CIRCUMSTANCES, e.g., "If I am in a persistent vegetative state or minimally conscious state with no prospect of recovery"]**

- **[SPECIFY CIRCUMSTANCES, e.g., "If I have severe brain damage with no prospect of recovery to a level where I can recognize and meaningfully interact with others"]**

Artificial Ventilation

I refuse artificial ventilation in the following circumstances:

- **[SPECIFY CIRCUMSTANCES]**

- **[SPECIFY CIRCUMSTANCES]**
- **[SPECIFY CIRCUMSTANCES]**

Artificial Nutrition and Hydration

I refuse artificial nutrition and hydration in the following circumstances:

- **[SPECIFY CIRCUMSTANCES]**
- **[SPECIFY CIRCUMSTANCES]**
- **[SPECIFY CIRCUMSTANCES]**

I understand that the law requires that a refusal of artificial nutrition and hydration must be stated in writing, be signed and witnessed, and include a statement that the refusal stands "even if life is at risk." I confirm that my refusal of artificial nutrition and hydration in the circumstances specified above stands even if my life is at risk as a result.

EXCEPTIONS TO TREATMENT REFUSALS

Notwithstanding the refusals above, I DO NOT refuse:

1. Basic nursing care, including mouth care and skin care.
2. Measures solely designed to provide comfort or relieve pain, distress, or discomfort.
3. The offering of food and drink by mouth.
4. **[OTHER EXCEPTIONS]**

PREGNANCY PROVISION

[CHOOSE ONE OF THE FOLLOWING OPTIONS:]

[OPTION 1: If I am pregnant when this Advance Decision is to be applied, all treatment refusals in this document are suspended for the duration of my pregnancy.]

[OPTION 2: If I am pregnant when this Advance Decision is to be applied, the following treatment refusals are suspended for the duration of my pregnancy: [LIST SPECIFIC REFUSALS]. All other refusals remain in effect.]

[OPTION 3: If I am pregnant when this Advance Decision is to be applied, all treatment refusals in this document remain in effect.]

LASTING POWER OF ATTORNEY FOR HEALTH AND WELFARE

[CHOOSE ONE OF THE FOLLOWING OPTIONS:]

[OPTION 1: I have NOT appointed a Lasting Power of Attorney for Health and Welfare.]

[OPTION 2: I have appointed a Lasting Power of Attorney for Health and Welfare. The attorney(s) details are:]

Name: **[NAME]**

Address: **[ADDRESS]**

Telephone: **[TELEPHONE]**

Email: **[EMAIL]**

Date LPA was made: **[DATE]**

I confirm that this Advance Decision is intended to take precedence over the decisions of my attorney(s) regarding the treatments I have specifically refused in this document.

STATEMENT REGARDING LIFE-SUSTAINING TREATMENT

I confirm that where I have refused treatment(s) that may sustain or prolong my life, my refusal of such treatment(s) is to apply even if my life is at risk as a result.

SIGNATURES

Person Making the Advance Decision

Signature: _____

Full Name: **[FULL NAME]**

Date: **[DATE]**

Witness

I witness the signature above and confirm that, to the best of my knowledge and belief, the person signing this Advance Decision:

- Has the mental capacity to make the decisions contained in this document
- Is signing this document voluntarily without pressure or undue influence from any other person

Witness Signature: _____

Full Name: **[FULL NAME]**

Address: **[ADDRESS]**

Telephone: **[TELEPHONE]**

Email: **[EMAIL]**

Relationship to person making the Advance Decision: **[RELATIONSHIP]**

Date: **[DATE]**

HEALTHCARE PROFESSIONAL STATEMENT (OPTIONAL)

I confirm that I have discussed this Advance Decision with the person named above. At the time of our discussion, the person had the mental capacity to make the decisions contained in this document and understood their nature and consequences.

Healthcare Professional Signature: _____

Full Name: **[FULL NAME]**

Professional Role: **[ROLE]**

Professional Registration Number: **[NUMBER]**

Contact Details: **[CONTACT DETAILS]**

Date: **[DATE]**