Advance Decision to Refuse Treatment

This form sets out the situations in which you want to refuse medical treatment if you are unable to make or communicate that decision in the future.

States of Jersey

Advance Decision to Refuse Treatment (ADRT).

This form sets out the situations in which I want to refuse medical treatment should I lack capacity to make or communicate that decision in the future. I have carefully considered these decisions and I confirm that I have capacity to make them. I understand that decisions about my diagnosis and prognosis will be made by the doctor in charge of my care.

If you have any questions or concerns regarding making an ADRT please discuss them with your GP or other medical practitioner involved in your care.

1. About me

Name: ....

Address: ....

Date of birth: .... URN number: ....

Distinguishing features: ....

2. GP details

Name: ....

Surgery: ....

Address: ....

Phone number: ....

3. I have discussed this ADRT with:

4. My refusals of treatment

I confirm that the following refusal(s) of treatment are to apply **even if my life is at risk or may be shortened** as a result.

I refuse all life-sustaining treatment if:

- I have been diagnosed with any of the conditions I have included in (A) to (D) below, and
- I can no longer make or communicate decisions about my medical treatment, and
- I am unlikely to regain the ability to make these decisions.

I understand life-sustaining treatment includes but is not limited to CPR, clinically assisted nutrition and hydration, acritical or mechanical ventilation and antibiotics for life-threatening infections.

(A)	Any type of dementia	Include ☐	Do not include ☐
(B)	Brain injury I understand that brain injury includes but is not limited to stroke, vegetative and minimally conscious states.	Include ☐	Do not include ☐
(C)	Diseases of the central nervous system I understand that a disease of the central nervous system includes but is not limited to motor neurone disease, Parkinson's Disease and Huntington's Disease.	Include ☐	Do not include ☐
(D)	Terminal illness	Include ☐	Do not include ☐

(Continued on next page)

(E) Refusing treatment in other situations :

I have included additional pages for section 4.E and have attached them to this form ☐

5. To avoid doubt

Pain relief I wish to be given all medical treatment to alleviate pain or distress, or aimed at ensuring my comfort.	Include ☐	Do not include ☐
Pregnancy If I am pregnant, I wish to receive medical treatment or procedures leading to the safe delivery of my child. Once my child is safely delivered I wish to reinstate my wishes as set out in this form.	Include ☐	Do not include ☐

6. Statement of wishes and feelings

This statement explains why I am making this ADRT and what is important to me in relation to my health, care, and quality of life.

I have included additional pages for section 6 and have attached them to this form ☐

7. I would like the following people to be consulted about my care

Name: .... Name: ....

Phone number: .... Phone number: ....

Relationship: .... Relationship: ....

8. I have also made a Lasting Power of Attorney for health and welfare

The details of my attorney(s) are:

Name: .... Name: ....

Address: .... Address: ....

....

Email: .... Email: ....

Phone number: .... Phone number: ....

9. Signature

I confirm that I have carefully considered my wishes as set out in this form and that all the information and decisions within it are my own.

Signature: .... Name: .... Date:..........................

10. Witness

I confirm that this ADRT was signed in my presence.

Signature: .... Name: .... Date:..........................

Address: ....

Relationship to the person making this ADRT: ....

11. Review dates

I have reviewed this ADRT and confirm that what is written reflects my wishes.

Signed: .... Signed: .... Signed: ....

Date: .... Date: .... Date: ....

Section 4.E ☐ Section 6 ☐ (continued)