



**PLANS FOR LIMITATION OF MEDICAL TREATMENT AT THE END OF MY LIFE**

I request that treatment aimed at prolonging life be withheld or stopped, and appropriate palliative care (for comfort and dignity) be provided, if, at some future time it is the opinion of the treating team responsible for my medical care that:

- significant recovery is highly unlikely, or
- the outcome of such treatment would be a permanent coma (or 'vegetative' state) or continuing progressive severe dementia; or
- any other state that is unacceptable to me (list below).

State any other outcomes of treatment or types of treatment that would be particularly unacceptable to you: (e.g. I fear being unable to speak and move myself, or, being able to communicate with my family is very important to me so I would not want life-prolonging treatment if I was unable to talk to them, or, I do not ever want to be put on a breathing machine, or I do not want to be fed through a tube.)

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**PLANS FOR MEDICAL TREATMENT GENERALLY WHEN I AM NOT DYING**

Other requests with regard to my medical care generally, such as circumstances in which I do or do not want a particular treatment (for example, an operation to treat a fractured hip.

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Any Specific directions should I develop **DEMENTIA/ALZHEIMERS DISEASE**

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**OTHER WISHES**

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*If there is not enough room to write all your requests and wishes, please attach further pages as necessary.*

*All additional pages need to be signed, dated and witnessed.*

Name of person completing this document

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**WITNESS**

It is assumed that a witness acts in good faith, and must:

- Be over 18;
- Be unrelated to the PERSON CONCERNED, and must not be a known beneficiary in that person's will;
- Confirm the identity of the PERSON CONCERNED and/or PERSON RESPONSIBLE
- Believe that the person understands that this document is about medical treatment decisions and
- Be confident that the person is under no duress or pressure

The witness can be a registered health care professional, but cannot be a paid personal carer.

Witness signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness name, address and contact details \_\_\_\_\_

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If you are registered as an organ, tissue or body donor, you may wish to attach your documentation to this plan.