Advance Decision to Refuse Specified Medical Treatment

1. I, _____ (print or type full name), born _____ (date) complete this document to set forth my treatment instructions in case of my incapacity. **The refusal of specified treatment(s) contained herein continues to apply to that/those treatment(s) even if those medically responsible for my welfare and/or any other persons believe that my life is at risk.**
2. I am one of Jehovah's Witnesses with firm religious convictions. With full realization of the implications of this position I direct that **NO TRANSFUSIONS OF BLOOD or primary blood components (red cells, white cells, plasma or platelets)** be administered to me in any circumstances. I also refuse to predonate my blood for later infusion.
3. **Regarding minor fractions of blood** (for example: albumin, coagulation factors, immunoglobulins): [Initial **one** of the three choices below.]

   (a) _____ I refuse all

   (b) _____ I accept all

   (c) _____ I want to qualify either (3a) or (3b) above and my treatment choices are as follows:

   _____

   _____
4. **Regarding autologous procedures** (involving my own blood, for example: haemodilution, heart bypass, dialysis, intraoperative and postoperative blood salvage):
   [Initial **one** of the three choices below.]

   (a) _____ I refuse all such procedures or therapies

   (b) _____ I am prepared to accept any such procedure

   (c) _____ I want to qualify either (4a) or (4b) above and my treatment choices are as follows:

   _____

   _____

   I am prepared to accept diagnostic procedures, such as blood samples for testing.
5. **Regarding other welfare instructions** (such as current medications, allergies, and medical problems):

   _____

   _____

   _____

6. I consent to my relevant medical records and the details of my condition being shared with the Emergency Contact below and/or with member(s) of the Hospital Liaison Committee for Jehovah's Witnesses.

7. _____ ____ ___ ___ ____ _____
Signature NHS No. Date

Address

8. **STATEMENT OF WITNESSES:** The person who signed this document did so in my presence. He or she appears to be of sound mind and free from duress, fraud, or undue influence. I am 18 years of age or older.

Signature of witness

Name Occupation

Address

Telephone Mobile

Signature of witness

Name Occupation

Address

Telephone Mobile

9. **EMERGENCY CONTACT:**

Name

Address

Telephone Mobile

10. **GENERAL PRACTITIONER CONTACT DETAILS:** A copy of this document is lodged with the Registered General Medical Practitioner whose details appear below.

Name

Address

Telephone Number(s)

NO BLOOD

(signed document inside)

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(signed document inside)

NO BLOOD