LIVING WILL OF
Mr John Benjamin Doe

SECTION A: DECLARATION

To my health care providers, my family, my solicitor and all others concerned in my care and treatment:

I confirm that I make this Living Will when I am of sound mind, and after full and careful consideration. This document is a true reflection of my wishes and values. I ask that its instructions and decisions be followed should I become unable to communicate my wishes in the future.

SIGNED: John Doe

Date: 16/09/14

Mr John Benjamin Doe
Regency House, 45 High Street,
Tunbridge Wells, Kent TN1 1XL

Born on 1957-10-25

SIGNATURE OF WITNESS

I declare that the above-named has signed this document in my presence. I am content that s/he is of sound mind and in full mental capacity, and makes this Living Will entirely of his/her own choosing, under no duress. I believe this document to accurately represent his/her wishes, and that s/he fully understands its implications.

SIGNED: John Smith

Date: 16/09/14

Name & Address of Witness

Dr John Philip Smith, 37b Greys Inn Road, London, WC1X 8LP

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SECTION B: ADVANCE DECISION

I Mr John Benjamin Doe declare that if at any time that if I suffer from any of the conditions or endure any of the states set out below ***and*** I am unable to make, participate in or communicate decisions about my care; ***and*** two independent physicians qualified to opine on the relevant issues confirm in writing that I am unlikely to recover from illness, or from lifelong impairment involving severe distress and that it is not in my best interests for any of the treatment set out below to be provided or continued.

My directions are as follows:

1. I wish to refuse the life-prolonging treatments indicated in the table below. **I understand that in refusing these treatments my life may be shortened.**

Circumstances	Treatment to be Refused
If I suffer from an **incurable terminal condition** expected to cause my death in a relatively short time (*such as cancer which has spread considerably and irreversibly*)	Artificial Ventilation, Artificial Feeding
If I suffer from **advanced degenerative disease of the nervous system** (*such as Motor Neurone Disease*)	Artificial Ventilation, Artificial Resucitation, Invasive Surgery
If I suffer **severe and lasting brain damage** (*including because of injury, stroke or disease*)	Artificial Ventilation, Artificial Resucitation, Artificial Feeding, Invasive Surgery, Dialysis, Blood Transfusions
If I suffer from **severely advanced dementia** resulting in limited awareness and inability to initiate simple tasks (*such as Alzheimer's*)	Artificial Ventilation, Invasive Surgery, Dialysis
If I am diagnosed as **severely and permanently mentally impaired**	Artificial Ventilation, Artificial Feeding, Dialysis
If I **am in a persistent vegetative state** and unlikely to regain consciousness (*such as in a comatose state from which I am unlikely to recover*)	Artificial Resucitation, Invasive Surgery, Blood Transfusions
Other	I would like to die as speedily and painlessly as possible. I do not want to disturb or cause a bother or expense to others by my passing. I should be allowed to die as nature intends without intervention. I wish to avoid the use of: Amputation A Colostomy Bag A Permanent Catheter

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SECTION B: ADVANCE DECISION (*cont*)

2. If I suffer any distressing or degrading symptoms (including those caused by lack of food or fluid), they should be fully controlled by appropriate palliative care, including pain-relieving treatments which may shorten my life.
3. If I suffer seriously distressing, degrading or painful symptoms which could be relieved by any of the treatments set out in section (1) above, those treatments may be used. However, this is on condition that the treatments are used purely for the purpose of elimination of those symptoms, and not for the short prolongation of life.
4. If treatment administered with the expectation of recovery proves futile, it must be discontinued immediately.
5. I absolve all those involved in my care and treatment from liability arising from acts and omissions carried out in accordance with this document. I thank them for their care, and their respect of my wishes.

SIGNED John Doe

Date 16/9/14

SIGNED (Witness) John Smith

Date 16/09/14

Name & Address of Witness

Dr John Philip Smith, 37-16 Greys Inn Road, London, WC1X 8LP

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SECTION C: ADVANCE STATEMENT

If at any time I am unable to make decisions or communicate my wishes about my care and treatment, I wish the following to be taken into account by my GP, specialists, nurses, other health care professionals, family and friends

Regarding medical treatment which is not essential to sustain or prolong my life

My fundamental belief is that I should be allowed to die with dignity and that my life should not be prolonged with aggressive medical treatment where the resulting quality of life is likely to be poor and where there is no reasonable expectation of recovery.

Regarding my general daily care and hygiene, including food and drink

I am happy to have daily care once I have reached a stage when my illness is terminal and my Wife is unable to care for me. I want to be kept clean, comfortable and pain free.

Regarding visitors and attendees during my illness

I am happy to have my Wife, Mother and Brother present as well as any other family and any close friends who want to be there.

Regarding my religious, ethical or moral values or convictions

I am a Catholic and would like to receive my last rites.

Regarding any other matters in which I wish my strongly-held views to be taken into account

Other than being given last rites, I do not wish to be visited by Chaplains of any creed. I do not want any payments or gifts of money being given to the Catholic Church, other than for costs normally associated with a funeral.

I would like to spend my final days At Home

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SECTION D: LASTING POWER OF ATTORNEY

I understand that the views and decisions set out in this document supersede any expressed by an individual to whom I have previously granted LPA with power to make decisions about life-sustaining treatment. I am aware that if I grant LPA with power to make decisions about life-sustaining treatment after the date of this document, their wishes will supersede those expressed here.

SIGNED _____

Date 16/5/16

SECTION E: FUNERAL ARRANGEMENTS

I wish my family, friends, and all others involved in my health care and legal affairs to take into account the following wishes and values when making arrangements for my funeral

I would prefer to be cremated, and my ashes scattered under the willow tree at the end of my garden in Manchester, with only family and close friends present.

SECTION F: ORGAN DONATION

I want all my organs or tissue to be used for transplantation or research after my death.

SIGNED _____

Date 16/5/16

support@uklivingwillregistry.co.uk

SECTION G: CONTACT IN CASE OF EMERGENCY

Name	Mr Leopold Bloom
Address	No. 7 Eccles Street, Dublin 7.
Telephone	07719227561

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Health Care Certificate of Capacity Notes

This following is an optional section which you may wish to have completed by your doctor.

Having a signed Health Care Certificate of Capacity attached to your Advance Decision / Living Will will make it much more difficult for someone to dispute your Advance Decision should they wish to, say a court.

You may wish to have your doctor fill out the Healthcare Certification of Capacity, but please be aware that they may charge you for their time.

Nevertheless, many believe that it is important to discuss the medical implications of the decisions you make in your Advance Decision with your doctor, or another medical professional.

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Healthcare Certification of Capacity

Name of Doctor Dr Mark Daniels

Medical Expertise General Practice Level of Seniority Senior GP (27 years practice)

I understand that by virtue of section 3 of the Mental Capacity Act 2005, in order to have mental capacity to take a decision a person must be able to:

- understand all information relevant to that decision; and
- be able to retain such information for so long as is required to take the decision; and
- weigh up that information as part of a decision making process; and
- communicate any decision reached.

I also understand that capacity is issue specific. By this it is meant that a person may be able to understand basic information and take basic decisions (what food to eat, what clothes to wear), but may lack capacity to take more serious decisions (such as refusing treatment).

I confirm that Mr John Benjamin Doe has been my patient for Seven years and that I reviewed Mr John Benjamin Doe on the following date 03/09/2014

Following this review I can confirm that Mr John Benjamin Doe was suffering from no mental or physical impairment such as to deprive Mr John Benjamin Doe of capacity to make an Advance Decision dealing with the future treatment specified in the Advance Decision.

I am treating Mr John Benjamin Doe for the following conditions

N/A

I discussed the contents of this Advance Decision with Mr John Benjamin Doe and made Mr John Benjamin Doe aware of the implications of the same.

SIGNED John Doe

Mr John Benjamin Doe Regency House, 45 High Street,
Tunbridge Wells, Kent TN1 1XL

Signed M.A. Daniels

Medical Professional Name & Address
Dr Mark Daniels, Herstmonceaux Health Centre, Herstmonceaux, E. Sussex BN27 4SX

Signed John Smith

Witness Name & Address
Dr John Philip Smith, 37 16 Greys Inn Road, London, WC1X 8LP