Advance Decision/Directive to Refuse Specified Medical Treatment

1. I, ______________________________ (print full name), born on:______________________(date of birth), complete this document to set forth my treatment instructions in case of my incapacity. The refusal of specified treatment(s) and medical procedures contained herein continues to apply to said treatment(s) and procedures even if those medically responsible for my welfare and/or any other relevant persons believe that **my life is at risk if not treated.**

2. With full realisation of the situation, I direct that no: organ transplants, skin or bone grafts, stem cells, invasive testing procedures, vaccinations, injections, and transfusion of blood or blood components (red cells, white cells, plasma, platelets, etc.) from persons other than my **NAMED BLOOD DONORS or pre-donated by me** be administered to me under **ANY** circumstances.

3. ☐ I have an Emergency Contact (ICE) or Next of Kin, or

   ☐ I have a Medical Guardian appointed under Lasting Power of Attorney (LPA)

4. ☐ This Advance Decision/Directive is compatible with the directives in my LPA

5. My LPA (if applicable) gives my Medical Guardian the authority to act on my behalf strictly within the limits of the directives in my LPA and Advance Decision/Directive with regard to: blood transfusions, organ transplants, skin or bone grafts, stem cells, invasive testing procedures, vaccinations, injections, and all other relevant medical treatments and procedures.

6. **This is a LEGAL NOTICE** and, as such, family members, relatives, friends, or medical practitioners may disagree with me, but such disagreement does not nullify my directives with regard to my rejection of blood or other instructions.

7. Regarding other **healthcare and welfare instructions** (such as my current medications, allergies, medical conditions, and additional healthcare wishes):

____

____

____

____

____

____

____

SAMPLE ADN

© My Medical Choice. All rights reserved.

8. I hereby give consent to my relevant medical records and details of my condition being shared with my Medical Guardian or ICE (see Section 10 for details).

Signature: ______________________ Date: ______________

Address: ____

9. **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	Signature of witness
______________________	______________________
Name	Name
______________________	______________________
Occupation	Occupation
Address: ______________	Address: ______________
______________________	______________________
Tel: __________________	Tel: __________________

10. ☐ **EMERGENCY CONTACT** ☐ **MEDICAL GUARDIAN**

____

Name

____

Address

____

____

Telephone

11. **GP CONTACT DETAILS:** A copy of this document is lodged with the Registered GP whose details appear below.

Dr: Name ______________________

____

Address

____

____

Telephone

Advance Health Care Directive

(signed document inside)

NO BLOOD

SAMPLE ADN

© My Medical Choice. All rights reserved.