

LIVING WILL

TO MY FAMILY, MY DOCTOR AND ALL OTHER PERSONS CONCERNED

(PLEASE COMPLETE IN INK IN BLOCK CAPITALS)

This Directive is made by me

Full name

of (*address*)

at a time when I am of sound mind and after careful consideration.

I declare that if at any time the following circumstances exist, namely:

1. I suffer from one or more of the conditions mentioned in the Schedule; and
2. I have become unable to participate effectively in decisions about my medical care; and
3. two independent doctors (one a consultant) are of the opinion that I am unlikely to recover from illness or impairment involving severe distress or incapacity for rational existence,

Then and in those circumstances my directions are as follows:

1. that I am not to be subjected to any medical intervention or treatment aimed at prolonging or sustaining my life;
2. that any distressing symptoms (including any caused by lack of food or fluid) are to be fully controlled by appropriate analgesic or other treatment, even though that treatment may shorten my life.

I consent to anything proposed to be done or omitted in compliance with the directions expressed above and absolve my medical attendants from any civil liability arising out of such acts or omissions.

I wish it to be understood that I fear degeneration and indignity far more than I fear death. I ask my medical attendants and any person consulted by them to bear this statement in mind when considering what my intentions would be in any uncertain situation.

I reserve the right to revoke this Directive at any time but, unless I do, it should be taken to represent my continuing directions.

SCHEDULE

- A. Advanced disseminated malignant disease (eg widespread lung cancer).
- B. Severe immune deficiency (eg AIDS).
- C. Advanced degenerative disease of the nervous system (eg motor neurone disease).
- D. Severe and lasting brain damage due to injury, stroke, disease or other cause.
- E. Senile or pre-senile dementia (eg Alzheimer's disease).
- F. Any other condition of comparable gravity.

I nominate *(delete if not applicable)*:

Full name

of *(address)*

Phone

as a person to be consulted by my medical attendants when considering what my intentions would be in any uncertain situation.

My General Practitioner is:

Full name

of *(address)*

Phone

Before signing this Directive I talked it over with my GP *(delete if not applicable)*

Signed by me:

(signature)

at *(place)* Date

We testify that the maker of this Directive signed it in our presence and made it clear to us that he/she understood what it meant. We do not know of any pressure being brought on him/her to make such a Directive and we believe it was made by his/her own wish. As far as we are aware, we do not stand to gain from his/her death.

Witnessed by:

(signature) *(signature)*

Full name Full name

of *(address)* of *(address)*

Date Date

In Scotland, a Living Will/Directive should be witnessed by a witness who should not be a relative, your Welfare Attorney, your Health Care Proxy or anyone who stands to gain from your death. The witnesses should sign at the same time as you and should then print their name and address in the spaces provided. Only one witness is actually required in Scotland, but no harm will be done if you have two.

In England and Wales, a second witness is required. They should both sign at the same time as you, and write 'witness' after their signature, and should then print their name and address in the spaces provided.

This Directive was reviewed and confirmed by me on the following dates *(sign your name each time you enter a date)*:

.....
.....
.....