scottish huntington's association

ADVANCE DIRECTIVE

Name:
Address:
Postcode: Date of Birth:
Telephone:

I have discussed the contents of the form with my GP Yes / No

And he / she has a copy of this form Yes / No

Name:
Address: Postcode:
Telephone:

I have discussed the contents of the form with the following health professional(s) and wish him / her to be consulted on health care matters Yes / No
And he / she has a copy of this form Yes / No

Name:
Address: Postcode:
Telephone:

I have made this declaration at a time when I am of sound mind and after careful consideration. I understand that the directive I have given in this form may shorten my life. I accept the risk that I may not be able to change my mind in the future at a time when I lack capacity.
I have given full consideration to the consequences of the decisions I have outlined in this directive.

I declare my wishes concerning medical treatment are as follows:

Life Threatening Condition

This is my intent if I develop one or more of the medical conditions listed in schedule 1 **and**

I have become unable to participate effectively in decisions about my medical care **and**

there is no reasonable hope of my making a substantial recovery.

Then in those circumstances:

A I want to be kept alive for as long as is reasonably possible using whatever forms of medical treatment are available. Agree / Disagree

B I do not want to be kept alive by life support systems. I want medical treatment to be limited to keeping me comfortable and free from pain with appropriate palliative care. Agree / Disagree

C I do not want to be resuscitated in the event of cardiac or pulmonary arrest. Agree / Disagree

I understand and accept that in the event of my medical condition involving risks relating to eating and swallowing, these are my wishes:

A **I would accept** PEG feeding as an alternative or to supplement oral feeding, if medically indicated. Agree / Disagree

B I accept the risks involved and have decided that I **do not wish** to accept PEG feeding as an alternative or to supplement oral feeding. Agree / Disagree

Schedule 1

The said medical conditions are:

a. Advanced disseminated malignant disease (eg cancer that has spread considerably).
b. Advanced degenerative disease of the nervous system (eg advanced Huntington's Disease).
c. Severe and lasting brain damage due to injury, stroke, disease or other cause.
d. Advanced dementia, whether Alzheimer's, multi-infract or other, resulting in very limited awareness of the immediate environment and inability to initiate simple tasks.
e. Any other condition of comparable gravity.

Personal Statement / Additional Wishes (for example treatment of infection with oral or intravenous antibiotics)

I have a welfare Power of Attorney Yes / No

Name:
Address: Postcode:
Telephone:

I do not have a Power of Attorney. I wish the following person to be consulted.
He / She is aware of my intentions and has a copy of this advance directive.

Name:
Address: Postcode:
Telephone:

Name:
Signature:
Date:

Witness Name:
Signature:
Address: Postcode:

Reviewed: Date:	Signature:
Reviewed: Date:	Signature:
Reviewed: Date:	Signature:
Reviewed: Date:	Signature:
Reviewed: Date:	Signature: