Supplement 17 – Advance Decision (previously Advance Medical Directive / Living Will)

Client Surname		First Names	

- **Further client details only required if instruction is for AD only**

Address																												
																						Postcode							
Email																Phone												
Date of Birth											Date of Birth																	
Testator 1 - AD	YES / NO															Testator 2 - AD	YES / NO											

- **An Advance Decision (Living Will) expresses the wish that in the event that you have a terminal illness with no hope of recovery, you would prefer not to be kept alive artificially but would prefer a natural, painless and dignified end to your life. It is a thoughtful gesture since your family will not face the anguish of making the decision for you.**
- **Appoint a Health Care Proxy to convey your written request to doctors in charge of your care. Your GP will keep your request on your medical record.**

1st Testator's GP Details	Dr.																2nd Testator's GP Details	Dr.															

Please state the name of your next of kin (or the person who would advise your doctors)

1st Testator's Health Care Proxy Details																	2nd Testator's Health Care Proxy Details																
Relationship to T1																	Relationship to T2																

A copy of your Advanced Decision will be provided for your General Practitioner and another to your Health Care Proxy (Perhaps your next of kin).

Please prepare the Advance Decision –
Signed:

Date		Date	