**EXAMPLE**

**ADVANCED DIRECTIVE**

**A COPY OF THIS SHOULD ACCOMPANY A SISTER TO HOSPITAL OR ANY CARE PROVIDER**

**PART 1: MY NAME AND CONTACTS**

1. Name

 …………………………………………………………………………

 Baptismal name (if different)

…………………………………………………………………………

 Religious name (if applicable) ………………………………………………………………………….

2. Date of Birth (Day/Month/Year)

…………………………………………………………………………

 Place of birth

 …………………………………………………………………………

3. Date of Entry into the Congregation

 ………………………………………….................................

4. Present Community and Address

 ………………………………………………………………………

5. My Local Community Contact is (name) ………………………………………………………………………….

 Phone Number(s) ………………………………………………………………………….

6. My Named Person from the Congregation is:

 Name: …………………………………………..

 Contact Details: ………………………………..

 I have informed the Named Person that I have named them. Yes/No

7. Family member(s) to be notified:

 Name(s) Relationship Phone number(s)

……………………………………............... (e.g. brother) ……………………………

………………………………………………. ………………. …………………………

 ……………………………………………… ………………. .………………………...

**PART 2: CARE NEEDS WHEN ILL OR FRAIL**

1. My National Insurance Number is ……………………………………………………

 NHS Medical Card Number …………………………………………………….

2. If I cannot take care of myself in my home or Community, (for whatever reason), my preference would be:

* to be cared for in a care home,
* to be cared for in a care home where there are other members of my Congregation or other. (please state below)

…………………………………………………………………………………………………………

3. Regarding my medical care:

i) In event of requiring medical care I <insert name> have decided I wish the following:

a) to be transferred to hospital and receive whatever treatment the Medical staff deem is appropriate

b) to be transferred to hospital for initial treatment but not to be put on a ventilator if my condition worsened

c) not to be transferred to hospital for treatment, (please discuss this with your Community before deciding on this)

ii) If the question arises concerning the administration of resuscitation, my wish is (please circle (a) or (b) below):

1. I do wish to be resuscitated
2. I do not wish to be resuscitated

I acknowledge that in making decisions to restrict care from health professionals may put my life at risk.

I confirm that I have had an opportunity to consider and reflect on these decisions that I wish to record.

I confirm that the decisions recorded in this Advanced Directive should be followed if I ever lack capacity to make treatment decisions for myself.

I confirm that I know that I am making decisions that will be effective even if it means that my life is at risk.

**These are my wishes:**

**Signed:** ………………………………………………………………….

**Date:** ………………………………………………………………….

**Witnessed:**

**Signed:** ………………………………………………………………….

**Full name:** ………………………………………………………………….

**Position in Congregation/relationship with individual:**

**Date:** ………………………………………………………………….

**Copy submitted to GP (name, address and GP’s details and date submitted to GP.)**

………………………………………………………………….

Notes:

[Mental Capacity Act Code of Practice - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice#history)