# Appendix B

## Advance Decision to Refuse Specified Medical Treatment

1. I, _____ (print or type full name), born _____ (date) complete this document to set forth my treatment instructions in case of my incapacity. **The refusal of specified treatment(s) contained herein continues to apply even if those medically responsible for my welfare and/or any other persons believe that such treatments are necessary to sustain my life.**
2. I am one of Jehovah's Witnesses with firm religious convictions. With full realization of the implications of this position I direct that **NO TRANSFUSIONS OF BLOOD or primary blood components (red cells, white cells, plasma or platelets)** be administered to me in any circumstances. I also refuse to predonate my blood for later infusion.
3. **Regarding minor fractions of blood** (for example: albumin, coagulation factors, immunoglobulins): [Initial **one** of the three choices below.]
   (a) _____ I refuse all
   (b) _____ I accept all
   (c) _____ I want to qualify either (3a) or (3b) above and my treatment choices are as follows:
   _____
   _____
4. **Regarding autologous procedures** (involving my own blood, for example: haemodilution, heart bypass, dialysis, intra-operative and post-operative blood salvage):
   [Initial **one** of the three choices below.]
   (a) _____ I refuse all such procedures or therapies
   (b) _____ I am prepared to accept any such procedure
   (c) _____ I accept only the following procedures:
   _____
   _____

   I am prepared to accept diagnostic procedures, such as blood samples for testing.
5. **Regarding other welfare instructions** (such as current medications, allergies, and medical problems):
   _____
   _____
   _____

dpa-E Bi 12/05 Page 1 of 2 Printed in Britain

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6. I consent to my medical records and the details of my condition being shared w Emergency Contact below and/or with member(s) of the Hospital Liaison Con for Jehovah's Witnesses.

7. _____ _____
Signature Date

_____
Address

8. **STATEMENT OF WITNESSES:** The person who signed this document did so presence. He or she appears to be of sound mind and free from duress, fraud, or influence. I am 18 years of age or older.

_____ _____
Signature of witness Signature of witness

_____ _____
Name Occupation Name Occupation

_____ _____
Address Address

_____ _____
Telephone Telephone

_____ _____
Mobile Mobile

---

9. **EMERGENCY CONTACT:**

_____
Name

_____
Address

_____
Telephone Mobile

10. **GENERAL PRACTITIONER CONTACT DETAILS:** A copy of this document is lodged with the Registered General Medical Practitioner whose details appear below.

_____
Name

_____
Address

_____
Telephone Number(s)



NO BLOOD

(signed document inside)

Advance Decision to Refuse Specified Medical Treatment

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**Advance Decision to Refus**
**Specified Medical Treatme**
(signed document inside)

NO BLOOD