THIS FORM IS NOT MANDATORY
Record of Decision and consent to Withdraw Implantable Cardioverter Defibrillator (ICD) Therapy in an Adult Patient

As the doctor currently caring for
Patient Name ……NHS number ……..
Address ……
DoB …….
Tick as necessary

- o I am satisfied that I have obtained the patient's informed consent to withdraw ICD therapy
- o I have the consent of the patient's Attorney (Named …….....) to withdraw ICD therapy. The Lasting Power of Attorney appointing him/her is registered and authorises him/her to make decisions on life sustaining treatment.
- o I have the consent of the deputy appointed by the Court of Protection (Named …….) to withdraw ICD therapy.
- o I am satisfied that a written advance refusal of ICD therapy exists, which is valid and applicable to current circumstances and I have the patients authority to withdraw ICD therapy.
- o I am satisfied that the patient lacks capacity to consent to withdrawal of treatment and confirm that I believe it is in the patient's best interests that ICD therapy should be withdrawn. I have attempted to establish /completed the necessary steps to ascertain /any relevant views/wishes of the patient prior to becoming incapacitated and have taken account of the views offered by this close to the patient (where available), the IMCA, where applicable , and the views of the multidisciplinary team.

Doctor Name

Position

Signature **Date**

I ……. (Print Patient's name)

Having been given the full details of the consequences by
Dr. ……..
agree to the deactivation of my Implantable Cardioverter Defibrillator (ICD). I understand that should I change my mind I can request reactivation of the device.

Signed ……..

Date ……..

The wording of this document has been over seen by a Solicitor from Hempsons