

Advance directive | Short version

Drawn up by

Name, first name _____

Date of birth _____ Place of residence _____

If I become incapacitated, it is my wish that:

all medically indicated measures (including resuscitation) should be taken to treat the acute condition so that I may regain capacity;

or

I should not be resuscitated and no intensive medical interventions (in particular ventilation) should be carried out;

or

I should not be resuscitated, but I consent to treatment in an intensive care unit.

If, after an initial stabilizing of my condition, it becomes clear that I am unlikely to regain capacity and that there is a high risk that I will require long-term care, it is my wish that:

all life-sustaining measures continue to be carried out, provided there is still hope that I may regain capacity;

no further life-sustaining measures are carried out.

In any event, I wish to receive effective treatment of pain and other distressing symptoms such as anxiety, restlessness, breathing difficulties and nausea.

I have appointed the following healthcare proxy whom I authorize to make my wishes known to the health care team. This person is to be informed about my condition and involved in decision-making; he/she can access my medical records, and I release all physicians and nursing staff from their duty of confidentiality vis-à-vis this person.

Name, first name _____

Address _____ Postcode/town _____

Tel. home _____ work _____ mobile _____

E-mail _____

If my healthcare proxy cannot be contacted or is unable for other reasons to exercise this responsibility, I designate the following substitute:

Name, first name _____

I have informed my healthcare proxy about this advance directive.

Name, first name of my general practitioner (GP) _____

Address _____ Postcode/town _____

Tel. home _____ work _____ mobile _____

E-mail _____

I have informed my general practitioner (GP) about this advance directive.

Organ donation

- I wish to donate my organs, and I consent to the removal of any organs, tissue or cells and to the implementation of the preparatory medical measures which are required prior to organ donation. I consent to the use of any intensive measures this may require.

- I consent only to the removal of _____

- I do not wish to be a donor.

Place, date _____

Signature _____

N.B. Please keep your advance directive in such a way that it can be found should the need arise. You can leave a copy with your general practitioner. Advance directives should not be sent to the FMH/SAMS. The SAMS guidelines on advance directives are available online at www.samw.ch, and further information on advance directives is available at www.fmh.ch > *Patientenverfügung*.