# Basel Advance Directive

Editor: Universitäre Altersmedizin FELIX PLATTER | GGG Voluntas | Medizinische Gesellschaft Basel | Universitätsspital Basel

| | |
|---|---|
| Surname, First name | |
| Date of birth | |

Current address

| | |
|---|---|
| Street / No. | |
| Postcode / City | |

Being of sound mind, I hereby declare the following in case I become incapable of decision-making.

## 1. Motivation

What motivates me to draw up an advance directive? Is there a specific reason?

## 2. My approach to life and death

An advance directive raises many questions about human existence: How do I see my own life and death? What illnesses am I suffering from? What is my experience of illness and dependence? What is the meaning of quality of life for me.
Personal considerations and values in terms of health, illness and death are a valuable guide when it comes to making medical decisions.

## 3. Situations in which the advance directive applies

Please check “Yes” for the responses that apply, and “No” for those that do not apply. If you cannot make a decision at the moment, please select U/d (= undecided).

This advance directive is valid for the following situations when a medical decision is necessary, and I am incapable of forming or expressing my own wishes:

| | Yes | No | U/d* |
|---|---|---|---|
| 1) If I am in the process of dying and it is expected that death is imminent. | ☐ | ☐ | ☐ |
| 2) If, due to serious illness or accident, my life could only be preserved by using extreme medical and technological interventions and there are no signs of improvement or recovery. | ☐ | ☐ | ☐ |
| 3) If I suffer from sudden serious brain damage (e.g. after a brain haemorrhage, a stroke or an accident) or an irreversible degenerative brain disorder (e.g. Alzheimer's disease), which are seriously compromising my ability to communicate and comprehend. | ☐ | ☐ | ☐ |
| 4) If, independently of situations 1, 2 or 3, a decision needs to be made for a treatment while I am hospitalized, for example, in the event of serious medical complications. | ☐ | ☐ | ☐ |

5) Other situations, comments:

## 4. General aims of medical interventions

Please check one as appropriate

a) ☐ or b) ☐

I hereby state that medical interventions should prioritize keeping me alive. I accept any consequences that may result from life-support measures. I only want to be allowed to die if all medical options have been exhausted.

I hereby state that medical interventions should prioritize my well-being and alleviate suffering. Priority should be given to treating symptoms, such as pain, respiratory distress, anxiety and fear. I understand that this may shorten my life.

Comments or additional remarks:

* For those statements marked with an asterisk, if you do not provide a response, your representative will be asked to decide in accordance with your presumed wishes. If you have not designated a representative, the law shall decide which relative or close friend should decide for you.

# 5. Special medical interventions

**1. Artificial administration of fluids or food**

If I am not able to ingest food or fluids naturally:

| | Yes | No | U/d* |
|---|---|---|---|
| a) I authorize the artificial administration of food and fluids (feeding tube, subcutaneous infusion). | ☐ | ☐ | ☐ |
| b) If I selected "No" above in a): I authorize the artificial administration of fluids but only to alleviate symptoms. | ☐ | ☐ | ☐ |

**2. Other interventions and comments**

# 6. Resuscitation

In the event of cardiac or respiratory arrest:

| | Yes | No | U/d* |
|---|---|---|---|
| I authorize attempts to resuscitate me (CPR). | ☐ | ☐ | ☐ |

Comments:

* For those statements marked with an asterisk, if you do not provide a response, your representative will be asked to decide in accordance with your presumed wishes. If you have not designated a representative, the law shall decide which relative or close friend should decide for you.

## 7. My representative

I hereby authorize my representative to inform the team treating me of my intentions. I hereby release the doctors and the whole medical team from their duty of confidentiality with regard to this person. This person should be informed as soon as possible. He or she is entitled to grant or deny consent to medical procedures. If my representative cannot be reached, the substitute representative should be contacted.

| | Representative | Substitute representative |
|---|---|---|
| Surname, first name | | |
| Street / No. | | |
| Postcode / City | | |
| Telephone P | | |
| Telephone W | | |
| Mobile | | |

Comments:

| |
|---|
| |

## 8. Additional information

| | |
|---|---|
| Preferred place for treatment and death: | |
| Instructions for medical care: | |
| Spiritual support: | |

| | Yes | No |
|---|---|---|
| Permission for the representative to access my medical records, even after my death | ☐ | ☐ |
| Autopsy | ☐ | ☐ |
| Organ donation | ☐ | ☐ |

Comments:

| |
|---|
| |

**My family doctor**

| | |
|---|---|
| Organization | |
| Surname, First name | |
| Street / No. | |
| Postcode / City | |
| Telephone | |
| Fax / Mobile | |

| | Yes | No |
|---|---|---|
| Does your doctor have a copy of this advance directive? | ☐ | ☐ |
| Should your doctor be informed if you are hospitalized? | ☐ | ☐ |

## 9. Depository and other provisions

Please check one box and provide additional details:

☐ Medizinische Notrufzentrale (MNZ)
Tel. +41 61 261 15 15

☐ Other depository:
(Address, Tel., name of contact person)

**Other personal provisions:**

| | Yes | No |
|---|---|---|
| Funeral provisions: | ☐ | ☐ |

Deposited with:

Comments:

## 10. Handwritten signature

| Place and date: | Signature: |
|---|---|
| | |

*Version November 2016 / the German version is the original version.*

*Reset form* *Print form*