Living will[i]

HOME CARE BERLIN E.V.

For reasons of improved readability the simultaneous use of different gender forms has been omitted in the following and the generic masculine is used instead. All personal designations shall be understood to apply equally to all genders.

I, _____ _____
(first name and surname of the authorising person) (date of birth)

_____ _____
(address of the authorising person) (telephone)

hereby decree with free, independent and uninfluenced will – until revoked – if I am no longer able to express my will, that in the following situations, my will be observed with regard to the decisions made.

Yes	No	Situations - and comparable situations - to which this shall apply:
☐	☐	1.) if, in all probability, I am inevitably in the process of dying
☐	☐	2.) if I am in the final stages of an incurable, terminal illness, even if the time of death is unforeseeable (e.g. high symptomic burden, sedation).
☐	☐	3.) if, in all probability, I have irretrievably lost my ability to function and decide autonomously, make decisions and socialise with other people as a result of a serious brain injury. This also applies if occasional reactions to external stimuli are observed and the time of death is not yet foreseeable. This applies to direct brain damage (e.g. due to accident, stroke, inflammation) and indirect brain damage (e.g. after resuscitation, shock, lung failure). I am aware that the ability to experience sensations may be preserved, but that an improvement in this condition is extremely unlikely. In the event of a vegetative state, I would like to limit life-sustaining measures to a maximum of ___ months **Yes** ☐ **Or** ☐ _____
☐	☐	4.) if I am no longer able to consume food and fluids naturally as a result of a very advanced brain degeneration process (e.g. dementia), even with persistent assistance. In the case of diagnosed advanced/terminal dementia and an additional life-limiting illness, I would like to receive curative therapies: **Yes** ☐ **No** ☐
☐	☐	_____ _____

After detailed advice I provided I hereby decree regarding the use of life-prolonging measures as follows:

	Yes	No
➢ Cardiovascular resuscitation using equipment and/or medication	☐	☐
➢ Cardiovascular resuscitation through manual cardiac massage	☐	☐
➢ artificial respiration via a tube (plastic tube) in the trachea/mask (mouth-nose)	☐	☐
➢ artificial hemodialysis in the event of kidney failure (dialysis)	☐	☐
➢ artificial nutrition via infusion, nasogastric tube through the nose or abdominal wall (PEG)	☐	☐
➢ artificial fluid supply via infusions or into the subcutaneous fatty tissue	☐	☐
➢ operation	☐	☐
➢ transfusion (transfer of blood or blood components)	☐	☐
➢ administration of antibiotics for bacterial-febrile inflammations	☐	☐

I expect humane, respectful and holistic treatment and care in my final years. I attach great importance to the natural quenching of hunger and thirst, good oral care and proper treatment at the end of life. I request the involvement of palliative medical/palliative care expertise if my attending physicians, nursing staff or authorised representative(s) have the impression that the care is otherwise insufficient and does not meet my needs.

Palliative indicated measures

I know that some of the measures mentioned above (as well as other measures such as drainage systems and decompression surgery) may be indicated for palliative purposes and can help to alleviate agonising symptoms and improve the quality of being in my final phase of life. In such a case, I would like them to be used, even if I have previously ruled them out as life-prolonging measures. **Yes** **No**

..... ☐ ☐

I ask for the best possible symptom control (relief of pain, breathlessness and other distressing symptoms) and accept that my life may be shortened as a result. **Yes** **No**

This includes targeted/palliative sedation ..... ☐ ☐

Supplementary remarks: _____

_____

In addition **Yes** **No**

- I wish to be contacted/visited by my relatives ..... ☐ ☐
- I wish, if possible, to die where I live ..... ☐ ☐
- I would like hospice assistance (outpatient and, if applicable, inpatient) ..... ☐ ☐
- I would like pastoral/spiritual counselling (_____) ☐ ☐
- I have created a health care proxy/power of attorney ..... ☐ ☐

The following person(s) is (are) hereby authorised: _____

_____

With regard to the authorised person(s), I release the doctors from their duty of confidentiality.

I request that the person(s) treating me agree with the person(s) authorised by me on all measures that should reasonably be taken or omitted in the course of my incapacity to give consent. The authorised person(s) is/are authorised to consent to or refuse measures, even if there is a risk that I will die or suffer serious, prolonged damage to my health; this shall also include changes to treatment goals and the discontinuation of treatment.

As part of the preparation of the living will, I have filled out a **values sheet**. This form is enclosed with this living will, so that both the doctors treating me and my authorised representative(s) can use it as a guide if anything is unclear. **Yes** ☐ **No** ☐

_____, _____ **_____**

Place **Date** **Signature of the authorising person**

Detailed advice was provided at _____ by _____

The advising counsellor hereby confirms that, at the time of counselling, the person making the decision was fully aware of the respective time, place and situation.

[i] As of: 17/2/2024, (ed: Home Care Berlin e.V., Brabanter Str.21, 10713 Berlin) The text of this living will was developed by Home Care Berlin e.V. using text modules from the corresponding form of the Federal Ministry of Justice and Consumer Protection.