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|  | | | | | | | | | **Notfallplan**  **Palliative Care** | | | | | | | | |  | | | | | | | |
| Personalien Patientin / Patient | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | |  | | | | | | | | | | |  | Geburtsdatum | | |  | | | | | | |
| **Vorname** | | | |  | | | | | | | | | | |  | **AHV-Nummer** | | |  | | | | | | |
| **Adresse** | | | |  | | | | | | | | | | |  | **Telefon** | | |  | | | | | | |
| **PLZ** | | | |  | | | | | | | | | | |  | **E-Mail** | | |  | | | | | | |
| **Ort** | | | |  | | | | | | | | | | |  | **Krankenkasse** | | |  | | | | | | |
| Wichtige Kontaktpersonen | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Bezugsperson:** | | | | |  | | | | | | | | | | | | | |  | Telefon |  | | | | |
| **Vertretungsbe- rechtigte Person:** | | | | |  | | | | | | | | | | | | | |  | Telefon |  | | | | |
| **Hausarzt:** | | | | |  | | | | | | | | | | | | | |  | Telefon |  | | | | |
|  |  | **Spitex / Pflege:** | | | | |  | | | | | | | | | | | |  | Telefon |  | | | | |
|  |  | **Seelsorge:** | | | | |  | | | | | | | | | | | |  | Telefon |  | | | | |
|  |  | **Freiwillige Nachtwache:** | | | | |  | | | | | | | | | | | |  | Telefon |  | | | | |
|  |  | **Weitere:** | | | | |  | | | | | | | | | | | |  | Telefon |  | | | | |
| Wesentliche Diagnosen / Angaben | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Wesentliche Diagnosen:** | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **Allergien / Unverträglichkeiten:** | | | | | | |  | | | | | | | | | | | | | | | | | | |
|  |  |  | Das vorliegende Dokument entspricht dem aktuell geäusserten Willen des Patienten. | | | | | | | | | | | | | | | | | | | | | | |
|  |  |  | Das vorliegende Dokument gilt als Ergänzung zur Patientenverfügung. | | | | | | | | | | | | | | | | | | | | | | |
|  |  |  | Das vorliegende Dokument entspricht dem mutmasslichen Patientenwillen. | | | | | | | | | | | | | | | | | | | | | | |
|  |  |  | Spitaleinweisung bei: | | | | | | | | | | | | | | | | | | | | | | |
|  |  |  | Symptomkontrolle erfolgt vorrangig im Pflegeheim/zu Hause, nur bei Erfolglosigkeit erfolgt Spitaleintritt mit Palliativbehandlung.  Palliativbehandlung. | | | | | | | | | | | | | | | | | | | | | | |
|  |  |  | Bei Bedarf kann der ärztliche Notfalldienst hinzugezogen werden; dieser handelt unter palliativmedizinischen Gesichtspunkten. | | | | | | | | | | | | | | | | | | | | | | |
|  |  |  | Der Patient darf bei der nächsten lebensbedrohlichen Verschlechterung versterben. | | | | | | | | | | | | | | | | | | | | | | |
|  |  |  | Die aktuelle Medikation ist überprüft worden, nicht notwendige Medikamente wurden abgesetzt. | | | | | | | | | | | | | | | | | | | | | | |
| **Bemerkungen:** | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Folgendes Vorgehen wurde vereinbart | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patientenverfügung vorhanden | | | | | |  | | JA | | NEIN |  |  |  | Ernährung (enteral) | | | | | | | |  | JA | NEIN |  |
| Reanimation | | | | | |  | | JA | | NEIN |  |  |  | Ernährung (parenteral) | | | | | | | |  | JA | NEIN |  |
| Antibiotikagabe | | | | | |  | | JA | | NEIN |  |  |  | Transfusionsbehandlung | | | | | | | |  | JA | NEIN |  |
| Beatmung (Intubation) | | | | | |  | | JA | | NEIN |  |  |  | Notfallset Medikamente liegt vor | | | | | | | |  | JA | NEIN |  |
| Intensivpflegestation | | | | | |  | | JA | | NEIN |  |  |  | | | |  | | | |  | |  |  |  |
| keine Abklärungsuntersuchungen | | | | | |  | | JA | | NEIN |  |  | Bemerkungen: | | | |  | | | | | | | | |
| - Ausnahme: | | | |  | | | | | | | | |
| Entscheidungsfindung | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Ziele / Wünsche / Hoffnungen der Patientin, des Patienten** | | | | | |  | | | | | | | | | | | | | | | | | | | |

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| Massnahmeplan / Symptomkontrolle bei | | | | | | | | | | | | |
| Angst, Unruhe, seelische Schmerzen | | | | | | | | | | | | |
| 1. | Beruhigen, ruhige Atmosphäre, gedämpftes Licht | | | | | | | | | | | |
| 2. | Medikamente einsetzen: | |  | | | | | | | | | |
|  | | | | | | | | | | | | |
| Schmerzen | | | | | | | | | | | | |
| 1. |  | | | | | | | | | | | |
| 2. |  | | | | | | | | | | | |
| 3. |  | | | | | | | | | | | |
| 4. |  | | | | | | | | | | | |
| Atemnot, Husten, Rasselatmung | | | | | | | | | | | | |
| 1. | Fenster und Kleider öffnen, aufsetzen, wenn möglich beruhigen | | | | | | | | | | | |
| 2. | Medikamente einsetzen: | |  | | | | | | | | | |
|  | | | | | | | | | | | | |
| Übelkeit, Erbrechen | | | | | | | | | | | | |
| 1. | Frische Luft, Fenster öffnen | | | | | | | | | | | |
| 2. | Medikamente einsetzen: | |  | | | | | | | | | |
|  | | | | | | | | | | | | |
| Verwirrtheit, Bewusstlosigkeit | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Verdauungsprobleme (Verstopfung, Durchfall)** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Hautverhältnisse (Juckreiz, Wunden, Dekubitus)** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Ernährung, Flüssigkeitszufuhr (Durst, Schleimhäute, PEG, Magensonde)** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Schlafstörungen, Müdigkeit, Schwäche | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Weitere Probleme | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Erfassung / Bestätigung Notfallplan | | | | | | | | | | | | |
| Teil ARZT | | | | | | | |  | | | | |
| Ort: | |  | | Datum: |  | Unterschrift: | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Teil PFLEGEFACHPERSON | | | | | | | |  | | | | |
| Ort: | |  | | Datum: |  | Unterschrift: | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| BESTÄTIGUNG PATIENT / BEZUGSPERSON | | | | | | | |  | | | | |
| Ort: | |  | | Datum: |  | Unterschrift: | |
|  | |  | |  |  |  | |  | | | | |
| Ort: | |  | | Datum: |  | Unterschrift: | |
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|  | |  | |  |  |  | |  |  |  |  |  |
| Ersetzt Version vom | | | | Datum: |  | |  | | | | | |
|  | |  | |  |  |  | |  |  |  |  |  |