**Organ Donation REFUSAL and living will**

supplementary to my living will dated **[date of your possibly existing living will]**.

**In the event of any contradictions or ambiguities, this Organ Donation REFUSAL takes precedence over all other declarations. This also applies if they are more recent.**

**My legal representatives are also bound by this refusal.**

Full name: **[Your full name]**

Born on **[your date of birth]** in **[your place of birth]**

Address: **[Your full registration address]**

My organ donation request is registered in [Austria, France and Italy].

1. **I expressly prohibit any kind of brain death diagnostics, including the apnea test, in the case of an unfavorable prognosis.**
2. **I prohibit to the removal of organs, tissues and/or bones.**
3. **I prohibit transfer from a peripheral hospital to the location of the transplant unit in the event of an infaust prognosis.**
4. **I prohibit any measures for donor conditioning and organ examinations for the purpose of subsequent organ removal. I also prohibit the discontinuation of painkillers and sedatives prior to brain death diagnostics.**
5. **I expressly prohibit the involvement of the German Organ Transplantation Foundation (DSO)** and/or any other organization whose aim is to procure organs and which is involved in the procurement and processing of organ transplants. **I expressly prohibit the disclosure of my data to the aforementioned organizations**.
6. **I exclude transplant officers (TxO) from treating me and accessing my data.** If the senior physician or head physician is the transplantation officer of the intensive care unit, I prohibit him in his function as TxO from carrying out diagnostic procedures and all other actions relating to the preparation and process of a transplantation on me (see 4.) **In his function as a physician treating me for my benefit (be it curative or palliative), he is of course permitted and desired to treat me to the best of his knowledge and belief, but not for the benefit of another, third person.**
7. In the event of foreseeable progression towards brain death symptoms or the certain prognosis of my imminent death, I would like my treatment to be switched to palliative therapy, after **consultation with and approval by** my legal representative.
8. Should my legal representative come to the conclusion **that it is sensible and necessary to involve an external doctor in my treatment, this doctor must be given access to me and my medical records.**
9. Should my legal representative come to the conclusion that it sensible and necessary to **transfer** me to **another hospital, I expressly agree to this**.
10. **My legal representative** is entitled to a copy of my **medical file** (§ 630g BGB). I hereby expressly release the doctors and nursing staff treating me from their duty of medical confidentiality. This also applies after my death.
11. **I also prohibit the implantation of organs, tissue and/or bones from third parties.**
12. **I prohibit participation in any studies.**

**My patient representative is:**

Full name: **[Full name of your patient representative]**

Telephone **[telephone number of your patient representative]**

Mobile **[mobile phone number of your patient representative]**

Address: **[Name of your patient representative]**

**[Place]**, **[Current date]**

*Your signature*

**[Your first and last name]**