Patient´s provision for consultation

by Serum-Depot Deutschland e.V.
in case of a bite by a venomous snake

Emergency calls (24/7): +49 30-5444 5989

Herewith I, _____, _____
(First name and surname) (Date of birth)

_____
(Address: Street, ZIP code, city, state)

explicitly release the doctors treating me in case of a bite by a venomous snake from their medical confidentiality towards medical and non-medical consultants of the 24-hours emergency call of the Serum-Depot Deutschland e. V. (SDD). I declare that I wish their enlistment for the support of my treatment in any case.

In this respect, I explicitly instruct the doctors treating me to give extensive medical information to the medical and non-medical consultants of the Serum-Depot Deutschland e.V. to enable them to give constructive advice for the treatment of my bite by a venomous snake according to my will.

Explanations for the attending doctor:

- Among other things, the consultant of the SDD can determine the appropriate serum for the treatment of the bite of a specified venomous snake. If the application should be necessary, the consultant can be helpful to the doctors treating me for getting the necessary serum.

- The consultant can only give advice if he is provided with facts, e.g. from a laboratory.

- The consultation may make the treatment for the attending doctor easier who probably has never before been confronted with such an emergency situation and may stimulate reasonable measures. Additionally it may help avoiding measures that are not reasonable (including incorrect or unnecessary applications of serum). This may lead to an optimum for the doctor and the patient as well. (1)

The attending doctor has the medical therapeutic sovereignty.

_____ _____ _____
Place Date Signature (Member of the Serum-Depot Deutschland e. V.)

(1) See WHO-references for treatment on the website (www.serumdepot.de)

Addition to patient´s provision for consultation

by Serum-Depot Deutschland e.V.
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Supplementary provision

for the case that there is only serum available past its expiration date.

I have read the information and explanations concerning this subject.

Supplementary provision to my patient´s provision, issued on _____

I explicitly agree
to the application of immune serum that is past its expiration date if there is no other appropriate serum available.

_____, _____
(First name and surname) (Date of birth)

_____
(Address: Street, ZIP code, city, state)

_____ _____
Place Date

_____
Signature (Member of the Serum-Depot Deutschland e. V.)