Clinic Bad Ragaz

Application for inpatient treatment/rehabilitation at the Clinic Bad Ragaz

(To be completed by the attending physician)

Surname _____ Telephone _____

First name _____ E-Mail _____

Street _____ Date of birth _____

Town/Postcode _____ Nationality _____

Country _____ Gende _____

For completion by the referring doctor/hospital

The above-mentioned person requires inpatient rehabilitation for the following reasons.

Reason for referral

☐ illness ☐ accident

a) Primary/secondary diagnosis

(Please enclose medical reports)

Functional deficit

b) Date of operation/accident _____

c) Comorbidities

Clinic Bad Ragaz AG
Hans Albrecht-Strasse 6
CH-7310 Bad Ragaz

Tel. +41 81 303 38 14
info@clinicragaz.ch
www.clinic-badragaz.ch

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2. Expected commencement of treatment _____

3. Requested duration of stay _____

4. Residence prior to commencing rehabilitation

☐ hospital ☐ at home

5. Medications

☐ no ☐ yes (If yes, please enclose a list of medications the patient is currently taking.)

Referring doctor/hospital

Name _____

Adress _____

Telephone _____ Place/Date _____

Stamp

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Patient condition survey

Surname/First name _____ Height _____

Date of birth _____ Weight _____

Mobility

☐ bedridden and/or bed rest
☐ needs help getting up/walking
☐ independent ☐ with support
☐ with frame ☐ with crutches ☐ with wheelchair
Transfer:
☐ independent ☐ with 1 person ☐ with 2 persons

Personal care

☐ full bed bath by assistant required
☐ personal care by assistant (washbasin)
☐ personal care with minimal support
☐ independent personal care
☐ may need help dressing and undressing

Toilet/bathroom

☐ urinary drainage/catheter
☐ faecal drainage/stoma
Type?
☐ colostomy ☐ nephrostomy ☐ ileostomy
☐ urinary or faecal incontinence
☐ toilet with assistance pot/urine bottle
☐ commode / WC with assistant
☐ independent WC use possible

Orientation

☐ extremely disoriented, requires constant supervision (very likely to wander off)
☐ disoriented, requires significant supervision (slight tendency to wander off)
☐ disoriented, requires supervision (not likely to wander off)
☐ slight, but relevant disorientation
☐ has temporal, spatial and mental self-awareness

Social interaction

☐ uncooperative/over-familiar/withdrawn
☐ very often ☐ fairly often ☐ sometimes ☐ rarely
☐ normal social interaction

Eating and drinking

☐ feeding tube / parenteral nutrition
Method of nutrition?
☐ transnasal feeding tube ☐ PEG tube
☐ spoon feeding / high risk of aspiration
☐ can sometimes eat unaided / generally needs help
☐ can eat fully independently

Communication

☐ no communication possible
☐ some communication possible, social contact severely restricted
☐ some communication possible, social contact moderately restricted
☐ adequate communication, but social contact slightly restricted
☐ no restriction on social contact

Mental state

☐ aggressiveness, euphoria, depression, apathy, anxiety
☐ high ☐ moderately severe ☐ mild
☐ mood swings
☐ appropriate behaviour and mental state

Specific information

☐ infusion/PIC/CVC/port ☐ sores/decubitus
☐ tracheostomy ☐ dialysis / peritoneal dialysis
☐ oxygen
☐ special medication _____
(Please enclose a copy of current medication list)

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Comments

Place/date _____

Signature/stamp _____

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