Clinic Bad Ragaz

Referral for in-patient treatment/rehabilitation

☐ General ward canton of residence only ☐ General ward all Switzerland ☐ Semi-private ☐ Private

Name/Forename _____ Postcode/Town _____

Street _____ AHV/OASI number _____

Tel. no. private _____ Basic insurance _____

Date of birth _____ Supplementary insurance _____

Your insurance categories and optional extras

- Premium private insurance in single room
- Private insurance in single room at an extra cost (on request)
- Semi-private insurance in single room at an extra cost (on request)
- General insurance canton of residence in single room at an extra cost (on request)
- General insurance CH/FL in single room at an extra cost (on request)
- Paying direct

Questions for referring doctor/hospital

Reason for referral: ☐ Sickness ☐ Accident Date occured: _____

Diagnosis / any secondary diagnosis
(Please enclose medical records)

Functional deficit:

Date of operation/accident: _____

Comorbidities:

Evidence of multi-resistant pathogens within the last 12 months? ☐ No ☐ Yes

If yes, please provide details? _____

If yes, will isolation or any other measures be necessary? _____

Expected date of starting treatment: _____

Preferred duration of stay: _____

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www.clinic-badragaz.ch

The finest Art
of *Rehabilitation*

Clinic Bad Ragaz

Treatment objective

Residence prior to commencing rehab ☐ Hospital ☐ At home

Is the patient taking any medication? ☐ Yes ☐ No

If yes, please send medication.

☐ In my opinion outpatient treatment is not an option.
A copy of this information will be sent direct to the medical officer of the health insurance company along with the reimbursement claim.

Name of referring doctor/hospital _____

Address _____

Tel. no. _____ Place, date _____

Please send additional documents (list of medication, medical records etc.).
Thank you.

Contact details and information for referrals

For patients from CH/FL:
Tel. +41 81 303 37 99
anmeldung.badragaz@kliniken-valens.ch

Für internationale Patienten:
Tel. +41 81 303 38 56
info@clinicragaz.ch

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Assessment of the patient's condition

Mobility

☐ bedridden and/or bed rest
☐ relies on wheelchair
☐ mobilisation with 1 assitant
☐ mobilisation with 2 assitants
☐ requires help sitting up

Walking

☐ independent
☐ with assistance
☐ walks with 1 assistant
☐ walks with 2 assistants
☐ with walking frame
☐ with walking sticks

Transfer

☐ independent
☐ with 1 assistant
☐ with 2 assistants
☐ full weight-bearing
☐ partial weight-bearing _____ kg
☐ _____

Personal care

☐ personal care in bed by assistant
☐ personal care by assistant (washbasin)

Upper body care

☐ patient manages without assistance
☐ with the support of an assistant
☐ performed in full by assistant

Lower body care

☐ patient manages without assistance
☐ with the support of an assistant
☐ performed in full by assistant

Requires assistance dressing and undressing

☐ upper body
☐ lower body

Showering

☐ capable of showering alone
☐ with the support of an assistant
☐ _____

Toilet/bathroom

☐ patient capable without assistance
☐ with the support of an assistant
☐ relies on bedpan / urine bottle
☐ urinary or faecal incontinence _____
☐ urinary drainage/catheter _____
☐ commode

Commode

☐ patient capable of using independently
☐ with the support of an assistant
☐ requires full assistance

Stoma

☐ able to care for stoma unassisted; what is the patient able to do: _____
☐ stoma care performed by assistant: _____
type of stoma:
☐ colostomy ☐ ileostomy ☐ nephrostomy
☐ urostomy
What material is it made of? _____

Orientation/alertness

☐ has temporal, spatial, situational and personal awareness
☐ slight disorientation, but relevant to everyday activity
☐ disorientated, requires supervision (not likely to wander)
☐ disorientated, requires a lot of supervision (slight tendency to wander)
☐ extremely disorientated, requires constant supervision (very likely to wander)
☐ sensor alarm floor mat
☐ bedside watch
☐ 1:1 care (24h)
☐ _____

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Breathing

☐ tracheotomy fitted
- ☐ laryngostomy ☐ tracheostomy
- ☐ cannula size _____

☐ fully cared for by assistant

☐ for which activities is support required?

_____

_____

☐ inhaler/nebuliser required

☐ oxygen required

☐ _____ litre/min.

☐ CPAP/BIPAP

Nutrition

☐ dysphagia / high risk of aspiration

☐ IDDSI level: _____

Via tube

☐ trans-nasal tube ☐ PEG tube ☐ PEJ tube

☐ type of nutrition by tube _____

☐ tube feeding
- ☐ administered in full by assistant
- ☐ patient capable unassisted _____

Parenteral nutrition

☐ enteral nutrition via: ☐ CVC ☐ PICC ☐ _____

☐ always requires assistance

☐ spoon-feeding

☐ can sometimes eat unassisted

☐ eats at all times without assistance

☐ _____

Understanding/communication

☐ foreign language ability _____

☐ no communication possible

☐ some communication possible, social contact somewhat impaired

☐ adequate understanding, social contact slightly impaired

☐ social contact unimpaired

☐ visual impairment

☐ blindness

☐ hearing impairment

☐ deafness

☐ _____

Mental health / social interaction

☐ stay in shared room possible

☐ appropriate behaviour and mental state

☐ depressive

☐ aggressive

☐ restless

☐ apathetic

☐ uncooperative

☐ overly familiar / no boundaries

☐ withdrawn

☐ dissociative seizures

☐ _____

Vascular access devices

☐ infusion _____

☐ PICC _____

☐ CVC _____

☐ portacath _____

Specific details

☐ isolation _____

☐ dialysis / peritoneal dialysis / haemodialysis

☐ drainage; if yes, what sort _____

_____

☐ lesions / bed sores _____

☐ special medication _____

Height _____ Weight _____

Please enclose additional documents such as list of medication and medical report. Thank you.

Place/date _____

Signature _____

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