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REFERRAL FOR INPATIENT TREATMENT/ REHABILITATION

☐ General division only canton of residence ☐ General department whole CH ☐ Semi-private ☐ private

Surname / First name _____ Date of birth _____

Street _____ Postcode / City _____

Tel. No. private _____ Insurer _____

Insurance information

☐ Private premium insurance in a single room

☐ Privately insured in a single room for an additional charge (on request)

☐ Semi-private insurance in a single room for an additional charge (on request)

☐ General insurance Canton of residence in a single room for an additional charge (on request)

☐ General insurance CH/FL in a single room for an additional charge (on request)

☐ Self-payer

Questions for the referring doctor/hospital

Reason for allocation: ☐ Illness ☐ Accident Event date: _____

Diagnosis / possible secondary diagnosis:

Functional deficit:

Date of operation / accident: _____

Concomitant diseases: _____

_____

Detection of multi-resistant pathogens in the last 12 months? ☐ Yes ☐ No

If so, which one? _____

If so, are isolation or other measures necessary? _____

_____

Expected start of treatment: _____

Desired length of stay: _____

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Treatment goal: _____

_____

Stay before the start of rehabilitation: ☐ Hospital ☐ at home

Is the patient taking medication? ☐ Yes ☐ No

If yes, please send a medication list.

☐ In my opinion, outpatient treatment is out of the question.
A copy of this information is sent directly to the health insurance company's to the medical examiner of the health insurance company.

Name of referring doctor / hospital _____

Address _____

Phone no. _____ Place, date _____

Please send additional documents (medication list, medical reports, etc.).
Thank you very much.

Contact and information for referrals

For patients from CH/ FL:
Daniela Frommelt
Team Leader Patient Scheduling
Phone +41 81 303 37 99
anmeldung.badragaz@kliniken-valens.ch

For international patients:
Manja Tusche
Leiterin Clinic Administration
Tel. +41 81 303 38 14
info@clinicragaz.ch

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ASSESSMENT OF THE PATIENT'S CONDITION

Surname / First name _____ Date of birth _____

Mobilisation

☐ bedridden or on bed rest
☐ needs help sitting up/walking
☐ self-employed ☐ with help
☐ mit Rollator ☐ with wheelchair
☐ with AUG

Transfer
☐ self-employed ☐ with 1 person ☐ with 2 person

Körperpflege

☐ Complete washing in bed by the carer
☐ Personal hygiene by an assistant (washbasin)
☐ Personal hygiene with minimal support
☐ Personal hygiene possible all by yourself
☐ needs help dressing and undressing

Excretion / Toilet

☐ Urine drainage / catheter
☐ Stool drainage / stoma
Which material: _____
☐ Colostoma ☐ Nephrostoma ☐ Ileostoma

☐ Urinary or faecal incontinence
☐ Excretion with the aid of a pot / urine bottle
☐ WC use alone possible

Orientation

☐ very disorientated, needs constant supervision (high tendency to run away)
☐ disorientated, needs a lot of supervision (high tendency to wander off)
☐ disorientated, needs a lot of supervision (high tendency to wander off)
☐ disorientated, needs supervision (without tendency to run away)
☐ Mild, but everyday-relevant orientation disorder
☐ Temporally, locally and autopsychologically orientated

Nutrition

☐ Tube / parenteral nutrition
What kind of nutrition? _____
☐ transnasal probe ☐ Nephrostoma
☐ spooning / high risk of aspiration
☐ eats completely independently

Communication

☐ No communication possible
☐ Partial communication possible, social contact severely impaired
☐ Partial communication possible, social contact moderately impaired
☐ Sufficient communication, but social contact slightly impaired
☐ Social contact unimpaired

Psyche

☐ Aggressiveness, euphoria, depression, apathy, restlessness
☐ strong ☐ moderate ☐ light
☐ Mood instability
☐ Adequate behaviour and psyche

Special features

☐ Infusion / PIC / ZVK / Port ☐ Wound / decubitus
☐ Tracheostoma ☐ Dialysis / peritoneal dialysis
☐ Oxygen ☐ _____
☐ special medicines _____

Size _____ Weight _____

Comments

Please enclose a copy of the most recent medication list.

Place / Date _____

Signature _____