KLINIKEN SCHMIEDER
Clinic for Neurology and Neurological Rehabilitation

QUESTIONNAIRE

FOR PATIENTS TO BE ADMITTED TO NEUROREHABILITATION

high quality in neurological rehabilitation

Patient´s details

NAME: _____

ADDRESS: _____

_____

_____

DATE OF BIRTH: _____

CONTACT PERSON:

Parents:	yes / no
Spouse/partner:	yes / no
Children:	yes / no
take care of patient:	yes / no
want to look after patient:	yes / no

ADDRESS OF THE CONTACT PERSON:
Name: _____
Street address: _____
Zip code: _____
Place of residence: _____
Phone: _____

COSTS PAID BY:
☐ Statutory health insurance company (HIC)
☐ Private HIC / Self-payer
☐ Employer's liability insurance association/accident insurance company
☐ Annuity insurance company
☐ Social welfare authority
Address: _____

_____

_____

CARER: _____

TRANSFERRED FROM:
☐ Intensive care unit
☐ Regular ward
☐ Home
☐ Nursing Home
Return possible: yes / no

ONSET OF DISEASE / DAY OF ACCIDENT: _____

DIAGNOSIS / DIAGNOSES:
1. _____
2. _____
3. _____
4. _____

COMPLICATIONS:

Seizures:	generalised / focal
Instable fractures:	yes / no
Heterotopic ossifications:	yes / no
Algodystrophy:	yes / no
Contractures:	yes / no
Infections:	yes / no
Multidrug resistant organisms (MDRO):	positive / 3x negative

PROVIDED WITH:
☐ Tracheostoma ☐ Pacemaker: type _____ ☐ Central venous catheter ☐ Shunt: type _____
☐ Urinary catheter suprapubic / transurethral / intermittent ☐ PEG ☐ Other tube _____
☐ Wheelchair active / electronic ☐ Rollator ☐ Forearm crutches ☐ Walking stick
☐ Prostheses: Extremity prostheses _____ Endoprostheses: cemented / uncemented ☐ Osteosynthesis

MALFUNCTION(S):
☐ Aphasia ☐ Dysarthria ☐ Dysphagia ☐ Disturbance of orientation ☐ Neuropsychological disorder ☐ Behaviour disorder
☐ Depression ☐ Psychosis ☐ Risk of suicide ☐ Hearing disorder ☐ Manifest addiction ☐ Neglect
☐ Visual disturbance: Hemianopsia/Amaurosis/Others: _____ ☐ Fracture: _____ Load-bearing capacity _____ kg
☐ Urinary catheter suprapubic / transurethral / intermittent ☐ PEG ☐ Other tube _____

COLLABORATION IN CARE AND THERAPY:
☐ Shows own initiative ☐ active ☐ passive ☐ reluctant

FURTHER TREATMENT: ☐ not settled ☐ settled
Where could the patient be transferred to after his / her treatment in our hospital if (s)he cannot be dismissed to his / her home?
[must be filled in necessarily]
ADDRESS: _____
PHONE: _____
CONTACT: _____

QUESTIONNAIRE – PART 2

1. Patient's condition must be monitored with intensive care	yes -50 / no 0
2. Tracheostoma	yes -50 / no 0
3. Intermittent ventilation	yes -50 / no 0
4. Disturbance of orientation (confusion) requires supervision	yes -50 / no 0
5. Behaviour disorder requires supervision (including threatening patient's own life or life of others, e.g. manifest suicidality)	yes -50 / no 0
6. Severe communication disorder	yes -25 / no 0
7. Dysphagia requiring supervision	yes -50 / no 0
8. Eating and drinking (with assistance, if food is cut up small before eating)	not possible 0 with assistance 5 without assistance 10
9. Getting from wheelchair to bed and vice versa (including: sitting up in bed)	not possible 0 with major assistance 5 with minor assistance 10 without assistance 15
10. Personal hygiene (washing face, combing hair, shaving, brushing teeth)	not possible 0 without assistance 5
11. Going to the toilet (Putting on/off clothes, wiping oneself properly, flushing the toilet)	not possible 0 with assistance 5 without assistance 10
12. Taking bath or shower	not possible 0 without assistance 5
13. Walking on the flat	not possible 0 wheelchair independent 5 walks with help 10 without assistance 15
14. Going up/down stairs	not possible 0 with assistance 5 without assistance 10
15. Dressing/undressing (including: tying shoelaces, fastening buttons)	not possible 0 with assistance 5 without assistance 10
16. Bowel control	not possible 0 with assistance 5 without assistance 10
17. Bladder control	not possible 0 with assistance 5 without assistance 10

CURRENT MEDICATION: _____

_____

_____

IMPORTANT: To be able to provide uninterrupted treatment and to plan an optimum therapy we ask you to make sure that the patient brings all medical reports, findings etc. (particularly X-ray, CT and NMR images) which you have received, AND the current medication when admitted to our hospital!

TRANSFERRING PHYSICIAN / INSTITUTION: _____ PHONE: _____