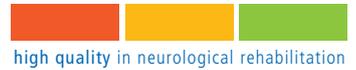


KLINIKEN SCHMIEDER

Clinic for Neurology and
Neurological Rehabilitation

QUESTIONNAIRE

FOR PATIENTS TO BE ADMITTED TO NEUROREHABILITATION



Patient's details

NAME: _____	DATE OF BIRTH: _____	ADDRESS OF THE CONTACT PERSON: Name: _____
ADDRESS: _____ _____ _____	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	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:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Tracheostoma | <input type="checkbox"/> Pacemaker: type _____ | <input type="checkbox"/> Central venous catheter | <input type="checkbox"/> Shunt: type _____ |
| <input type="checkbox"/> Urinary catheter suprapubic / transurethral / intermittent | <input type="checkbox"/> PEG | <input type="checkbox"/> Forearm crutches | <input type="checkbox"/> Other tube _____ |
| <input type="checkbox"/> Wheelchair active / electronic | <input type="checkbox"/> Rollator | <input type="checkbox"/> Walking stick | |
| <input type="checkbox"/> Prosthesis: Extremity prostheses _____ | Endoprosthesis: cemented / uncemented | <input type="checkbox"/> Osteosynthesis | |

MALFUNCTION(S):

- | | | | | | |
|---|--|---|---|--|---|
| <input type="checkbox"/> Aphasia | <input type="checkbox"/> Dysarthria | <input type="checkbox"/> Dysphagia | <input type="checkbox"/> Disturbance of orientation | <input type="checkbox"/> Neuropsychological disorder | <input type="checkbox"/> Behaviour disorder |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Psychosis | <input type="checkbox"/> Risk of suicide | <input type="checkbox"/> Hearing disorder | <input type="checkbox"/> Manifest addiction | <input type="checkbox"/> Neglect |
| <input type="checkbox"/> Visual disturbance: Hemianopsia/Amaurosis/Others: _____ | <input type="checkbox"/> Fracture: _____ | Load-bearing capacity _____ kg | | | |
| <input type="checkbox"/> Urinary catheter suprapubic / transurethral / intermittent | <input type="checkbox"/> PEG | <input type="checkbox"/> Other tube _____ | | | |

COLLABORATION IN CARE AND THERAPY:

- | | | | |
|---|---------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> Shows own initiative | <input type="checkbox"/> active | <input type="checkbox"/> passive | <input type="checkbox"/> 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: