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Questionaire to determine the scope of care and contact information

Details of the applicant

		m	w
Name and Surname of the resident	Birthdate	Gender	
Adress			
ZIP	Place		
Phone no.	Accessibility		
Health insurance	Insurance company / Member ID		
Care insurance	Insurance company / Member ID		
Travel insurance	Insurance company / Member ID		

Details of the reference person / confidant

Name and Surname (main contact for emergency)	Name and Surname (main contact for emergency)
Address	Address
ZIP / Place	ZIP / Place
Phone (privat) / Phone (business)	Phone (privat) / Phone (business)
email	email
accessibility	accessibility

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Information about family doctor

Name of the family doctor | Phone no.

Address / ZIP / Place

Note:
If you decide to stay with us, we kindly ask you to provide us with the latest medical report from your doctor about medications and treatments.

Diseases

Which diseases and / or disabilities you suffer?

Dementia
Alzheimer
Parkinson
Other illness

In which care level you are classified?

- ○ Care level I
- ○ Care level III
- ○ Care level II
- ○ Not classified

Do you need a walking stick, rollator or wheelchair?

- ○ Walking stick
- ○ Wheelchair
- ○ Rollator
- ○ Need no help

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Voice and sleep behavior

The language comprehension is …..

- ◯ completely preserved
- ◯ largely obtained
- ◯ limited
- ◯ limited to gestures
- ◯ others

The sleep behavior is …..

- ◯ sleep well and calm
- ◯ difficulty falling asleep
- ◯ Staying asleep problems
- ◯ Day and night reversal
- ◯ Need sleeping pills

Remark:

Body care and motion

Need help / at or on ….

- ◯ wash, showering or bathing
- ◯ personal care in general
- ◯ going to the toilet
- ◯ Change of incontinence material
- ◯ Change of urinary catheter
- ◯ Change of ostomy bag
- ◯ other assistance necessary ….
- ◯ No help needed

Do you need help going to bed or getting up?

- ◯ yes
- ◯ no
- ◯ sometimes

Do you need help by dressing and undressing of clothes?

- ◯ yes
- ◯ no
- ◯ partially

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Remark:

Food and Drinking

Do you need assistance by eating and drinking?

- ◯ yes
- ◯ no
- ◯ sometimes
- ◯ No help needed

Need to follow a diet, if so, which?

- ◯ no, i can eat all
- ◯ yes , i need a diet (please specify)

Which …

Do you have a food allergy?

- ◯ no, or unknown to me
- ◯ yes (please specify)

on what
…………..

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Medicaments

What prescribed medication you need to take it? Specify (name of the drug)

in the morning
at lunchtime
in the evening
before sleep
no medication

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Do you have an allergy to specific drugs?

- ◯ no, or unknown to me
- ◯ yes (please specify)

on what

Do you need help with the administration of the medication?

- ◯ By setup of tablets and assistance in taking, check
- ◯ Help with injections (for example, insulin)
- ◯ assistance during inhalation
- ◯ No help needed

Vital signs monitoring and observation

What controls were prescribed by the doctor?

- ◯ Lead a fluid or drinking balance
- ◯ Daily blood glucose monitoring
- ◯ Repeated Quick value control
- ◯ No checks are necessary or prescribed

Is special care required?

- ◯ Treatment of pressure ulcers (bedsores)
- ◯ Catheter care
- ◯ Supply of a nasogastric tube
- ◯ No special care required

Intensiv care

What care measures must be carried out?

- ◯ Aspiration of the air passages
- ◯ Bladder irrigation by indwelling catheters
- ◯ Changing the urinary catheter
- ◯ Change the gastric tube
- ◯ Have no care needs

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Remark:

Date: ____________________	Signature: Applicant ______________________________
Date: ____________________	Signature: Reference person ______________________________