

# 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 refe	erence 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		



# 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.

	Disease	S	
Which dis	seases and / or disabilities you suffer?		50
Dementia			
Alzheimer Parkinson			
Other illne	SS		
		. WN W	
In which	care level you are classified?	VV	
00	Care level I Care level III	0	Care level II Not classified
Do you need a walking stick, rollator or wheelchair?			
00	Walking stick Wheelchair	00	Rollator Need no help



# Voice and sleep behavior

### The language comprehension is .....

O completely preserved largely obtained limited limited to gestures others

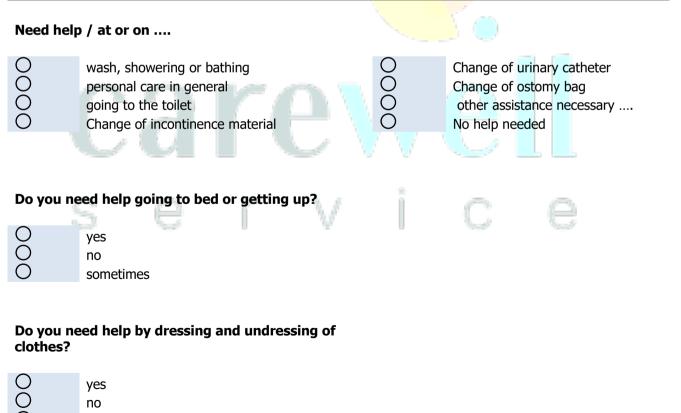
### **Remark:**

## The sleep behavior is .....

00000

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

# **Body care and motion**





## **Remark:**

Food and Drinking
Do you need assistance by eating and drinking?
O yes   O no   Sometimes   No help needed
Need to follow a diet, if so, which?
O no, i can eat all yes , i need a diet (please specify)
Which
Do you have a food allergy?
O no, or unknown to me yes (please specify) on what
service
Medicaments

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

•	1 7 1	57
in the morning		
at lunchtime		
in the evening		
before sleep		
no medication		



## Do you have an allergy to specific drugs?

0	no, or unknown to me
0	yes (please specify)
on what	

## Do you need help with the administration of the medication?

(	)	
(	)	
(	)	
$\left( \right)$	)	

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?

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

## Is special care required?

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

# **Intensiv** care

## What care measures must be carried out?

C	)
(	)
(	)
(	)
C	)

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



Remarl	k:
Date:	Signature:
	Applicant
Date:	Signature: Reference person
	COKONA CO
	service