

Medical Patient Form

Patient Information*

Salutation

First name*

Last name*

Date of birth *

dd-MMM-yyyy

Country of residence

Phone number *

Nationality

Email *

Address

Street & house number

native language

Post code

City

language of correspondence *

English

German

Disease to be treated

Disease exists since *

Preferred entry date

dd-MMM-yyyy

Diagnosis *

Stroke

Traumatic brain injury

Multiple sclerosis

Spinal cord injury

Parkinson's disease

other disease

Does the patient have a legal representative? *

yes

no

Contact information of legal representative

Salutation

First name

Last name

Email legal representative

Phone number legal representative

Medical information

Please tick where applicable

Is the patient mechanically ventilated? *

yes

no

Movement

Please tick the appropriate

Weakness or abnormal stiffness of the arm

yes

no

Which arm?

right

left

both

Extent of weakness / abnormal stiffness

light

medium

severe

Weakness or abnormal stiffness of the leg

yes

no

Which leg?

right

left

both

Extent of weakness / abnormal stiffness

light

medium

severe

Perception & language

Is the patient awake? *

yes

partially

no

Please tick the appropriate box

	no	mild	moderate	severe
Impairment of spacial orientation	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain / mood disorder	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatigue / somnolence / unconsciousness	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Impairment of swallowing	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Impairment of cognition / memory	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Impairment of language	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

Can the patient communicate him-/herself?

- yes no

Daily activities

Please tick the appropriate

Eating & drinking

- independent help required

Dressing: Requires assistance when dressing

- no, completely independent yes, partially yes, fully dependent

Number of assistants

Mobility

Please tick the appropriate

- independent
- Independently possible with tools (e.g. stick/cane, walker, wheelchair)
- Requires an accompanying person to walk
- Can NOT move independently (e.g. wheelchair)
- Is bedridden and must be moved by a caregiver

Bladder and toilet use

Please tick the appropriate

Complete continence

- yes, completely continent no, occasionally incontinent
 no, frequently incontinent no, completely incontinent

Incontinence with

- Urine Bowel movement both

Aiding tools

- permanent catheter pants urinal condom

Do you need help to clean yourself or change pants / sanitary napkins?

- yes no

Support from nursing staff

Please tick the appropriate *

- yes no

Nursing staff

- on call 1:1 support

Preference nursing staff

- only female only male no preference

Objectives of patient / other medical information you want to share