ATTENDING PHYSICIAN'S CONTACT DATA

TEL: MAIL:

Polish Centre of
Functional Rehabilitation VOTUM

REHABILITATION REFERRAL REQUEST

To: Polish Centre of Functional Rehabilitation VOTUM

PATIENT DATA

NAME SURNAME

PERMANENT ADDRESS
STREET HOME NO POST-CODE CITY

PESEL ID CARD NUMBER TELEPHONE

CURRENT CAREGIVER

NAME SURNAME

STREET HOME NO. POST-CODE MIEJSCOWOŚĆ

DISEASE/INJURY DATE EMAIL: TEL:

Rehabilitation conducted ☐ YES ☐ NO Financed: ☐ by NHF ☐ Own funds

*DELETE AS APPROPRIATE

I hereby kindly ask for being referred to rehabilitation at the Polish Centre of Functional Rehabilitation VOTUM Spółka Akcyjna Spółka Komandytowa with the registered seat in Krakow. I hereby consent to the processing of my personal data and medical records for the purpose of rehabilitation services provided by the Polish Centre of Functional Rehabilitation VOTUM Spółka Akcyjna Spółka Komandytowa with its registered seat in Krakow.

Pursuant to the provisions of the Personal Data Protection Act, the Requester confirms to have been informed that:

1. The Controller of the subject's personal data is the Polish Centre of Functional Rehabilitation VOTUM Spółka Akcyjna Spółka Komandytowa with the registered seat in Krakow 30-723, at Golikówka 6, registered at the District Court for Krakow Śródmieście, 11th Economic Division of the National Court Register under the number KRS: 0000443718
2. The subject's personal data shall be collected in connection with services provided by the Polish Centre of functional Rehabilitation VOTUM Spółka Akcyjna Spółka Komandytowa and may be used for the Centre's business purposes,
3. The Requester shall have the right to access their data and have inaccurate personal data rectified on conditions specified in the Personal Data Protection Act.
4. Submission of personal data is necessary to examine the Rehabilitation Referral Request and the data subject shall be deemed to have consented to the processing of personal data contained in the referral request by the data controller – the Polish Centre of Functional Rehabilitation VOTUM Spółka Akcyjna Spółka Komandytowa with its registered seat in Krakow 30-723, at ul. Golikówka 6 – for the purpose of examining the request and for marketing purposes.

PLACE AND DATE SIGNATURE

(To be filled out by a referring physician) Diagnosis code IC10. Underlying diseases and coexisting conditions. Surgeries, procedures.

NEUROLOGY

State of consciousness ☐ Awake ☐ Waking up ☐ Vegetative state

GCS level points*

Comments

*If GCS level is below 10, neurological assessment is required.

Current head CT with interpretation date..... Report enclosed ☐ YES ☐ NO

Valve Implantation ☐ YES ☐ NO valve model.....

Muscle tone

☐ high ☐ stiffness ☐ spasticity where?
☐ normal where?
☐ low ☐ limpness ☐ Amyotonia (EMG) where?

Contractures

☐ none ☐ occurring where?

Psychomotor agitation (PMA) ☐ YES ☐ NO

Deep (proprioceptive) sensation

☐ normal ☐ disturbed where?

Superficial (exteroceptive) sensation

☐ normal ☐ disturbed where?

INTERNAL MEDICINE

Height . . . . . **Weight** . . . . . .

CRP date ..... PCT date . . . . . .

Rectal smears for multi-resistant strains (VRE, MBL).

MBL date.....OTHER date . . . . . .

VRE date.....ESBL date . . . . . .

IONOGRAM

MORPHOLOGY

Chest X-ray * ☐ YES ☐ NO interpretation encl. ☐ YES ☐ NO

*Please, enclose x-ray report

COVID-19 Test Result date . . . . . .

Edema ☐ YES ☐ NO Location
Wounds ☐ YES ☐ NO Type
Pressure ulcers ☐ YES ☐ NO Area Stage

Circulatory system

Blood pressure mmHG Cardioverter inserted ☐ YES ☐ NO

Heart rate ☐ regular ☐ abnormal ca. /min

Respiratory system

☐ efficient ☐ inefficient ☐ tracheostomy ☐ assisted ventilation ☐ Oxygen therapy

Tracheostomy tube type

date .....

Date inserted/replaced . . . . . .

Secretion in bronchial tree

Comments

Gastrointestinal system

☐ Stomach tube ☐ PEG Oral nutritional support ☐ YES ☐ NO

Dietary recommendations

Urinary system

Urinary catheter ☐ YES ☐ NO

Catheter type

Urine culture date .....

Catheter problems ☐ YES ☐ NO

Date inserted/ replaced .....

Bowel control ☐ YES ☐ NO

Current pharmacological treatment

Antibiotic therapy in last two weeks

Antipyretic drugs in last two weeks

Current pharmacological treatment

Category of nursing care: ☐ I ☐ II ☐ III ☐ IV Justification:

Neoplastic diseases ☐ YES ☐ NO

ORTHOPAEDICS

Type of injury

Post-operative ☐ YES ☐ NO

Type of surgery

Up-to-date X-ray ☐ YES ☐ NO Report enclosed ☐ YES ☐ NO

Up-to-date orthopaedic consultation ☐ YES ☐ NO Report enclosed ☐ YES ☐ NO

Locomotor system

☐ Contractions ☐ Amyotrophy Anastomosis ☐ YES ☐ NO

Type of anastomosis

Contraindications for MRI ☐ YES ☐ NO

Patient's locomotion

Bedridden	☐ YES	☐ NO	
Walking	☐ assisted	☐ independent	☐ can't walk
Using a wheelchair	☐ assisted	☐ independently	☐ can't move
Wheelchair	☐ own	☐ rented	☐ no wheelchair

Speech and Communication

☐ Without disorders ☐ disruption what kind?

Motivation in rehabilitation ☐ YES ☐ NONE ☐ difficult to assess

ACTIVITIES OF DAILY LIVING

Able to accomplish activities of daily living ☐ YES ☐ NO

If not, what activities need assistance?

Is the Patient capable of doing the following activities:

- prepare his/her own meals ☐ YES ☐ NO
- eat ☐ YES ☐ NO
- dress up ☐ YES ☐ NO
- daily hygiene routine ☐ YES ☐ NO
- Taking a bath ☐ YES ☐ NO
- transferring from bed to chair ☐ YES ☐ NO
- getting up from chair ☐ YES ☐ NO
- Taking the stairs ☐ YES ☐ NO

Is the patient moving independently? ☐ YES ☐ NO

Is the patient moving with the help of another person or orthopaedic equipment? ☐ YES ☐ NO

Is the patient moving independently:

- only around the apartment? ☐ YES ☐ NO
- is the patient capable of going shopping? ☐ YES ☐ NO
- is the patient capable of going for walks? ☐ YES ☐ NO If yes, what distance?

I hereby confirm that all the data contained in the application is true and consistent with the current health status of the patient. Upon request of the qualification team, I undertake to provide the results of imaging tests, laboratory tests, wound / rectal swabs or intra-stay medical history reports.

PLACE AND DATE

PHYSICIAN'S SIGNATURE AND SEAL

Please, enclose copies of the neurological and orthopaedic consultations, CT, MRI and X-ray results, and the results of microbiological tests.