ATTENDING PHYSICIAN'S CONTACT DATA						
TEL:		MAIL:				



REHABILITATION REFERRAL REQUEST

To: Polish Centre of Functional Rehabilitation VOTUM

PATIENT DATA								
NAME	SURNAME							
PERMANENT ADDRESS STREET	HOME NO POST-CODE CITY							
PESEL								
CURRENT CAREGIVER								
NAME	SURNAME							
	POST-CODE MIEISCOWOŚĆ							
STREET	HOME NO. POST-CODE MIEJSCOWOŚĆ							
DISEASE/INJURY DATE EMAIL:	TEL:							
	Rehabilitation conducted YES NO Financed: by NHF Own fur							
*DELETE AS APPROPRIATE	o rehabilitation at the Polish Centre of Functional Rehabilitation VOTUM Spółka Akcyjna Spółk							
eferral request by the data controller – the Polish the purpose of examining the request and for ma ND DATE SIGNATURE (To be filled out by a referring physic	ı Centre of Functional Rehabilitation VOTUM Spółka Akcyjna Spółka Komandytowa with its registered seat in Krakow 30-723, at ul. Gı							
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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	Superficial (exteroceptive) sensation								
normal disturbed	where?								
INTERNAL MEDICINE									
Height Weight									
CRP	datePCT	date							
Rectal smears for multi-resistant strains (V	/RE, MBL).								
MBL	dateOTHER	date							
VRE	dateESBL	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 Stag	ge							
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									
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	indepen	dent		can't walk			
Using a wheelchair	assisted	indepen	dently		can't move			
Wheelchair	own	rented	•		no wheelch	air		
Speech and Communication								
<u> </u>								
Without disorders dis	sruption what kir	10 ?						
Motivation in rehabilitation	YES	NOI	NE		difficult t	to assess		
ACTIVITIES OF DAILY LIVI	NG							
Able to accomplish activities of	of daily living	YES	NO	0				
If not, what activities need ass								
Is the Patient capable of doing			0					
prepare his/her own mealseat			0					
• dress up			0					
 daily hygiene routine 			0					
• Taking a bath			0					
 transferring from bed to cha 	ir Y	ES N	0					
getting up from chair	YI	ES N	0					
Taking the stairs			0					
Is the patient moving independent	criciy.		0					
Is the patient moving with the		erson or orth	nopaedi	ic equ	ipment?	YES	NO	
Is the patient moving indeper			_					
only around the apartment?is the patient capable of goir			0					
• is the patient capable of goir		=	O If	VOC 1	what distan	.e3		
vis the patient capable of gon	ig ioi waiks:	L3 IN	0 11	yes, v	wiiat uistain	ce:		
•								
hereby confirm that all the data of								
oon request of the qualification te		provide the re stay medical l				ooratory te	sts, wound /	rectal swabs
	or mera s	otay mealean	iistoi y i	срогс	J.			
PLACE AND DATE						PHYSICIAN'	S SIGNATURE	AND SEAL