VALMONT
Clinique privée de réadaptation

Clinique Valmont
Service des Admissions
Route de Valmont 22
CH-1823 Glion sur Montreux

T +41 21 962 37 40
F +41 21 962 39 39
admissions@cliniquevalmont.ch

Admission questionnaire

LAST NAME/First name : ……

Date of Birth : ..... Marital status : ..... Gender :……

Address: ..... Profession : ……..

ZIP code/Location : ..... Language : ……

Private phone : ..... Emergency contact number : ……

Type(s) of insurance(s):	Compulsory insurance ❒ General hospital ward	Supplemental insurances ❒ Semi-private	 ❒ Private
Insurance NAME :	.....	.....	.....
Patient Insurance Number :	.....	.....	.....
Phone / Fax :	.....	.....	.....

Hospital / Clinic – Refering / Operating physician : ……

Address : ..... ZIP code/Location :……..

Phone : ..... Fax :……

Request entry date : ..... **Estimated** length of stay: ……..

Patient location prior to arrival at Clinique Valmont : ……

Has the patient already stayed at Clinique Valmont ? | If yes, when ?

General Practitioner + Location : ……

Diagnostics for rehabilitation:

❒ Illness :..... ❒ Accident : ..... ❒ Accident consequence(s) :……

Date ode vent, accident and/or surgical intervention: ……

Diagnosis know by the patient ❒ Yes ❒ No **MRSA** : ❒ Yes ❒ No

Neurological disorders:

❒ Parkinson ❒ Alzheimer ❒ Myelopathy ❒ MS ❒ Cognitives disorders ❒ Stoke ❒ Other :……

Comorbidities :

❒ Diabetes ❒ Hypercholesterolemia ❒ Obesity ❒ renal failure ❒ Other :……..

Medical documents to provide us:

- ❒ **Medical background**
- ❒ **Laboratory results**
- ❒ **Radiological report**
- ❒ **Images and/or CDs**
- ❒ **Medical treatment**
- ❒ **Release letter**
- ❒ **Operative report**

Lifestyle and social project :

Habitat : ❒ Apartment ❒ House ❒ EMS ❒ Other :……

Family and social entourage: ❒ Lives alone ❒ Family-Neighbor ❒ Housekeeper ❒ Sick guard
❒ Carrying meals ❒ Tele-alarm ❒ Curatelle ❒ CMS ❒ OSAD

Social project : ❒ Back home ❒ Existing aid ❒ Aids to be provided ❒ Orientation in EMS to be envisaged

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Admission questionnaire

Name : ..... **First name** : .....

Patient condition : In order to examine the admission request in detail, we ask you to fill in the following questionnaire with the assistance of the **nursing staff.**

Personal hygiene

Bed ❑ assistance :.....❑ alone
Lavabo ❑ assistance :.....❑ alone
Shower ❑ assistance :.....❑ alone

Complete autonomy ❑

Getting dressed / undressed

Top ❑ assistance :.....❑ alone
Bottom ❑ assistance :.....❑ alone
Auxiliary material .....

Complete autonomy ❑

Moving

Positioning / Bed ❑ assistance :.....❑ alone
To get up / Transfer ❑ assistance :.....❑ alone
Walking ❑ assistance :.....❑ alone

❑ Walking stick
❑ Roller
❑ Whell chair
❑ Electric chair

Provided by patient ?
❑ yes ❑ no

Complete autonomy ❑

Elimination

Urinary incontinence ❑ yes ❑ no
Fecal incontinence ❑ yes ❑ no
Use of restrooms ❑ assitance :..... ❑ alone

❑ Tube ❑ vesical ❑ cystostomy
❑ Condom ❑ day ❑ night
❑ Protection ❑ day ❑ night

Complete autonomy ❑

Food

Serving ❑ assistance :.....❑ alone
Cut the food ❑ assistance :.....❑ alone
Eat / Drink ❑ assistance :.....❑ alone
Dysphagia ❑ assistance :.....❑ alone

Tube ❑ oui
❑ non

Complete autonomy ❑

Diet

❒ Hypo caloric
❒ Diabetic
❒ Digestive saving
❒ Hyper proteinated
❒ Cut
❒ Hypo cholesterol
❒ No salt
❒ Rich in fibres
❒ Tube
❒ Mixed

❒ Food allergies: ……
……

Physical condition

Height :…… Weight……

Skin condition

❑ Eschar Location:……..……..
❑Air matress ……..
❑ Wound (specify) ……..
❑ Dressing ……..

Psychological condition ❑ Unremarkable

❒ Aggressive / euphoric
❒ Apathetic / depressive
❒ Risk of running away
❒ Adequate / emotional stability
❒ Dementia
❒ Other : ……

Orientation ❑ Good

Spatial

❑ Disorientated
❑ Partial orientation

Temporal

❑ Disorientated
❑ Partial orientation

Memory ❑ Good

Aptitude to remember / find back an information

❒ Major difficulties
❒ Minor difficulties

Communication ❑ Bonne ❑ Aphasia

Comprehension

❑ Impossible
❑ Partial affected

Expression

❑ Impossible
❑ Partial affected

Problem solving ❑ Independence

(Organisation, decision taking, etc.)

❒ Total assistance
❒ Partially dependant

Place : **Date :** **Stamp :** **Signature of referring physician :**