VALMONT
Clinique privée de réadaptation

ADMISSION QUESTIONNAIRE

This questionnaire has 2 pages. We thank you for returning it duly completed to admissions@cliniquevalmont.ch.

Patient

Last name: _____ First name: _____

☐ M ☐ F Date of birth: ____ / ____ / _____ Address: _____

Private phone: _____ Emergency contact number: _____ Emergency contact: _____

Insurance/Division	Compulsory insurance	☐ Semi-private	☐ Private	☐ Self-pay patient
Insurance name	_____	_____	_____	
Patient Insurance Number	_____	_____	_____	

Requested entry date: ____ / ____ / _____

Refering/Operating physician: _____ Phone: _____ Email: _____

Hospital/Clinic:

Liaison nurse: _____ Phone: _____ Email: _____

Patient location prior to arrival at Clinique Valmont: _____

General Practitioner + Location: _____

Diagnosis for rehabilitation

Please state the diagnosis for rehabilitation:

Case: ☐ Illness ☐ Accident

Date of the event, accident and/or surgical intervention: ____ / ____ / _____

Diagnosis known by the patient: ☐ Yes ☐ No Isolation: ☐ Yes _____ ☐ No

Comorbidities: Current treatments:

Medical history:

We kindly ask you to send us the following documents as soon as possible:

- Medical transmission document or temporary release letter
- Medico-Social Document of Transmission, imaging, last laboratory, electrocardiogram if available
- Release letter
- Operative report

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Activities of Daily Living (ADL)

	Alone	Partial assistance	Full assistance
Personal hygiene	☐	☐	☐
Getting dressed/ undressed	☐	☐	☐
Food and drink	☐	☐	☐
Moving	☐	☐	☐

⇒ Specify: ☐ Walking stick ☐ Roller ☐ Wheelchair ☐ Electric chair

Other ADL clarification: _____

Elimination

Urinary incontinence ☐ Yes ☐ No

Fecal incontinence ☐ Yes ☐ No

Catheter ☐ Yes ☐ No

If yes, specify: _____

Swallowing disorders ☐ Yes ☐ No

If yes, specify the texture: _____

Feeding tube ☐ Yes ☐ No

If yes, specify: _____

Special diet ☐ Yes ☐ No

If yes, specify: _____

Breathing

☐ Normal ☐ O2: ____ l/min ☐ CiPAP ☐ BiPAP

Physical condition

Height: _____ cm Weight: _____ kg

Skin condition

☐ Eschar ☐ Wound with particular protocol

Location/care: _____

☐ Air matress

☐ Dressing

Specify: _____

Psychological condition

☐ Unremarkable

☐ Aggressive/euphoric

☐ Apathetic/depressive

☐ Risk of running away

☐ Adequate/emotional stability

☐ Dementia

☐ Other: _____

Lifestyle and social project

Housing: _____

Family and social entourage:

_____

Social project: _____

Orientation

☐ Good

Spatial

☐ Disorientated

☐ Partial orientation

Temporal

☐ Disorientated

☐ Partial orientation

Memory

☐ Good

(Aptitude to remember/find back an information)

☐ Major difficulties

☐ Minor difficulties

Communication

☐ Good ☐ Aphasia

Understanding

☐ Impossible

☐ Partially affected

Expression

☐ Impossible

☐ Partially affected

Problem solving

☐ Independence

(Organisation, decision taking, etc.)

☐ Full assistance

☐ Partially dependant

Place: _____

Date: ____ / ____ / _____

Stamp:

Signature of referring physician: