**Dom za starije osobe Korčula**

**Ulica 58,br.2**

**20260 Korčula**

**LIJEČNIČKA POTVRDA ZA PRIJEM U DOM**

**IME I PREZIME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATUM I MJESTO ROĐENJA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADRESA STANOVANJA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PODACI O ZRAVSTVENOM STANJU**

**1.DIJAGNOZA**

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**2.POKRETNOST**

1. **Potpuna b) djelomična c) nepokretan d) pomagalo \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3.OSOBA BOLUJE OD DUŠEVNE BOLESTI**

1. **DA b) NE**

**Ako DA navesti od koje:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**4.PSIHIČKO STANJE OSOBE:**

1. **Orijentiran b) djelomično orijentiran c) neorijentiran**

**5.OSOBA JE: a) Pokretna ( funkcionalno neovisna osoba ) I. stupanj**

**b) Teže pokretna ( djelomično ovisna osoba ) II. stupanj**

**c) Nepokretna ( funkcionalno ovisna osoba ) III. stupanj**

**d) Funkcionalno ovisna osoba kojoj je zbog Alzheimerove demencije ili drugih demencija ( srednji/ srednje teški stadij bolesti ) potrebna pomoć i nadzor druge osobe u zadovoljavanju svih potreba u punom opsegu**

**6.ZARAZNO OBOLJENJE**

**a) postoji, koje\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ b) ne postoji**

**7. JE LI OSOBA LIJEČENA OD ALKOHOLIZMA: a) DA b) NE**

**8. JE LI OSOBA LIJEČENA OD HEPATITISA: a) DA b) NE**

**9. JE LI OSOBA LIJEČENA OD TUBERKULOZE: a) DA b) NE**

**10. KONTINENTNOST: a) kontinentan b) inkontinentan**

**11. POMOĆ I NJEGA DRUGE OSOBE:**

**a) Nije potrebna b) Potrebna je: - kod održavanja osobne higijene**

**- kod oblačenja**

**- kod hranjena**

**- kod kretanja**

**- kod uzimanja propisane terapije**

**12. DIJETALNA ILI DRUGA POSEBNA PREHRANA:**

**a) Nije potrebna b) Potrebna je – navesti kakva**

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**13. DOSADAŠNJA TERAPIJA:**

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**14. IME I PREZIME, ADRESA I BR. TELEFONA ODABRANOG LIJEČNIKA:  
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**Mjesto i datum: Potpis liječnika:**

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