記載日：平成　 　年　 　　月　 　日

医療法人財団　青南病院　医療相談窓口

TEL:0178-27-2015　FAX:0178-27-9500

**転院・入院依頼患者様情報**

送付者：　医療機関名（施設名）

氏名　　　　　　　　　　　　　　　　　　　　　職種

TEL:　　　　　　　　　　　　　　　　　　　　　FAX:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| ふりがな |  | |  | | | | | 男 ・ 女 | | 明治・大正・昭和 | | | |  | | | | | 年 | | |  | | | 月 | |  | | | | 日生 | | | | |  | | | 歳 | | | | |
| 患者氏名 |  | |  | | | | |
| 住所 | 〒 |  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | TEL： | | | | |  | | | | | | | | | | | |
| 主 病 名 |  | | | | | | | | | | | | | | | 発症日 | | | | | |  | | | | | 年 | | |  | | | | 月 | | |  | 日 | | | | | |
| 合併症  既往症 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 経過 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 現在の状況 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 転院(入院)  依頼の理由 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 保険種別 | ・健康保険　　・国民健康保険　　・共済組合　　・生活保護　　・後期高齢者医療 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ・重度医療　　・特定疾患（ | | | | | |  | | | | | | | | | | | | | ）　　・その他（ | | | | | | | |  | | | | | | | | | | | | | | ） | |
| 介護保険 | ・要支1　　・要支2　　・要介1　　・要介2　　・要介3　　・要介4　　・要介5　　・未申請 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ケアマネジャー　　無　・　有　（事業所名: | | | | | | | |  | | | | | | | | | | | | | | 担当者名: | | | | | |  | | | | | | | | | | | | | ) | |
| 家族構成 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| キーパーソン（氏名 | | |  | | | | | | 続柄 |  | | | | | | ) | 介護者（氏名 | | | | | | | |  | | | | | 続柄 | | | |  | | | | | | ) | |
| 移動 | 自立　　一部介助　　全介助　　ベッド上生活　（　寝返り：　可　・　不可　） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 歩行 | 独歩　　一部介助　（　杖　　歩行器　　車椅子　） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 食事 | 自立　　一部介助　　全介助　　経管栄養　（　経鼻　　胃ろう　　腸ろう　） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 食種 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 排泄 | 自立　　ポータブル　（　自力　　半介助　）　　全介助　（　オムツ　　バルーン　） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 入浴 | 自立　　一部介助　　全介助 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 着替え | 自立　　一部介助　　全介助 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 麻痺 | 無　・　有　（部位 | | | |  | | | | | | | | | | ） | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 拘縮 | 無　・　有　（部位 | | | |  | | | | | | | | | | ） | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 褥瘡 | 無　・　有　（部位 | | | |  | | | | | | | | | | ） | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 認知症 | 無　・　有　（　アルツハイマー型認知症　　脳血管性認知症　　その他＜ | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | ＞） | | | |
| 問題行動 | 無　・　有　（　興奮　暴力　暴言　大声　抵抗　拒食　拒薬　徘徊　不眠　せん妄　その他＜ | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | ＞） | | | |
| 感染症 | 無　・　有　（　HBs　HCV　TPHA　MRSA＜検出部位： | | | | | | | | | | | |  | | | | | | | | | | | ＞　その他＜ | | | | | | | | |  | | | | | | | ＞） | | | |
| 現在の処置内容や特別な医療 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ・点滴の管理　　・中心静脈栄養　　・人工肛門　　・膀胱ろう　　・酸素療法　　・喀痰吸引　　・インスリン投与　　・気管切開 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ・経管栄養（　経鼻　　胃ろう　　腸ろう　）　　・疼痛の看護　　・その他（ | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | ） | | | |
| 看護上の問題点 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 今後の方向性 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ・在宅　　・施設（申請の有無を含め | | | | | |  | | | | | | | ）　　・未定　　・その他（ | | | | | | | | | | | | |  | | | | | | | | | | | | | | ） | | | |
| その他の連絡事項 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |