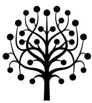

SANTA LUCIA
NEUROSCIENZE E RIABILITAZIONE

Date ....

Request for hospitalization at Santa Lucia Foundation IRCCS

Please fill all fields and send to: **ricoveri@hsantalucia.it** or fax: **+39 06 5032 097**

1. TYPE OF HOSPITALIZATION

1a ☐ Public Health System **Hospitalization** ☐ Public Health System **Day Hospital** ☐ **Private Hospitalization** ☐ **Private Day Hospital**

If the patient has private insurance, please indicate the name of company

2. PATIENT'S DATA

2a Last Name | First Name | ☐ **M** ☐ **F**

2b Place of Birth | Country | Date of Birth

2c Address: Street | Number

2d Town | State / Country | Postal Code

2e Phone | E-mail (not obligatory)

2f **Patient Record Number assigned by the sending Hospital**

2g ☐ **THE PATIENT IS ITALIAN CITIZEN** | Tax Code

2h ID Number | Released by the Administration

2i ☐ **THE PATIENT IS NOT ITALIAN CITIZEN AND CAN SHOW**

2m ☐ TEAM Form ☐ ENI Code ☐ E111 Form ☐ STP

3. HISTORY AND CURRENT CLINICAL CONDITIONS

3a **Diagnosis and lesion site for which the hospitalization is required**

3b Patient's height (m) | Patient's weight (Kg) | Date of onset of disease | Barthel Index (overall score)

3c ☐ **Spinal cord lesion** ☐ **The patient was in coma**

3d **Length of coma (number of days) at the sending Hospital** | **Glasgow Coma Scale Value by hospitalization at the sending Hospital**

3e **Other diseases,** including contagious diseases or healthy carrier state

3f **Isolation required** ☐ Yes ☐ No

Mod. 9.2 Rev. 11 01/09/2015

3g ....
Scope of rehabilitation

3h ....
Place where the patient is now. If hospitalized, please write the Hospital's name.

3i ....
Current therapy

3m ....
Previous hospitalizations (acute)

3n **Previous hospitalizations for rehabilitation** ☐ Yes .... When ☐ No

Patient underwent surgery ☐ Yes .... Kind of surgery .... Date of surgery

3p **Exams (please attach responses)**

☐ ECG ☐ MRI ☐ CT scan ☐ Ultrasound ☐ Electromyogram

3q	**General conditions**	☐ Good	☐ Passable	☐ Low
3r	**State of consciousness**	☐ Awake	☐ Clouded	☐ Bewildered
3s	**Collaborates**	☐ Yes	☐ No	
3t	**Respiratory problems**	☐ Yes	☐ No	☐ Yes, with oxygen therapy
3u	**Feeding**	☐ per OS	☐ Enteral	☐ Parental
3v	**Tracheostomy in progress**	☐ Yes	☐ No	
3w	**Bedsores**	☐ Yes *	☐ No	

....
* Indicate site and stage

3x	**Urinary bladder**	☐ Continent	☐ Incontinent
3y	**Rectal**	☐ Continent	☐ Incontinent
3z	**Alcohol / drug addiction**	☐ Yes	☐ No

4. MOTOR, NEUROPSYCHOLOGICAL, AND SPEECH DEFICITS

4a ....
Joints limitations

4b	**Voluntary movements**	**Upper right limb**	☐ Preserved	☐ limited	☐ absent
		Lower right limb	☐ Preserved	☐ limited	☐ absent
		Upper left limb	☐ Preserved	☐ limited	☐ absent
		Lower left limb	☐ Preserved	☐ limited	☐ absent

4c **Upright position** ☐ Yes ☐ No **Sitting position** ☐ Yes ☐ No

4d	**The Patient wanders**	☐ Yes	☐ No		
4e	**Load contraindications**	☐ Yes *	☐ No	.... * Length of load capacity	
4f	**Neuropsychological and speech deficits**	☐ Aphasia	☐ Dysarthria	☐ Apraxia	☐ No
4g	**Dementia**	☐ Yes	☐ No		

5. POST-COMA SYNDROME

(Please fill this section in case of a request for post-coma patient rehabilitation)

5a	**Patient can stare and gaze**	☐ Yes	☐ No
5b	**executes simple orders**	☐ Yes	☐ No
5c	**spontaneously moves one or more limbs**	☐ Yes	☐ No
5d	**displays decortication or decerebration posture**	☐ Yes	☐ No
5e	**displays psychomotor agitation**	☐ Yes	☐ No
5f	**needs oral nutrition**	☐ Yes	☐ No
5g	**displays hyperthermia / recurrent infections**	☐ Yes	☐ No

DOCTOR PRESCRIBING THIS HOSPITALIZATION

Last Name .... First Name .... ID Regional Code (if assigned) ....

Hospital .... Operative Unit ....

Phone .... Email or Fax available for replay of Santa Lucia Foundation ....

Date .... Doctor’s signature ....

IMPORTANT: please enclose photocopy of health card and patient identity document

The data contained in this form will be treated in accordance with Decree 196/2003, as amended. The data controller is the Santa Lucia Foundation IRCCS.

OUTCOME OF THE REQUEST

(reserved for Santa Lucia Foundation IRCCS)

☐ **Request accepted** Patient in waiting list ☐ **Request declined** ☐ **Patient will be called for evaluation** ☐ **Additional information required**

Notes ....

....

Date .... Signing on behalf of the Medical Commission ....