**Zdravstveni zavod, zasebna ambulanta**

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**MNENJE O ZDRAVSTVENEM STANJU  
za uveljavljanje pravice do socialno varstvene storitve**

Priimek in ime......................................................................................................................

EMŠO..................................................................................................................................

Stalno prebivališče................................................................................................................

Diagnoze:............................................................................................................................  
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Dosedanja terapija: ..............................................................................................................  
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| **Gibanje**: | transperentcheck normalno | transperentcheck delno oteženo | transperentcheck nepomičen/na |
|  |  |  |  |
| **Sluh:** | transperentcheck sliši | transperentcheck naglušen/na | transperentcheck gluh/a |
| **Vid:** | transperentcheck vidi | transperentcheck slaboviden/na | transperentcheck slep/a |
| **Govorna komunikacija:** | | transperentcheck mogoča | transperentcheck ni mogoča |
| **Medicinsko-tehnični pripomočki:** | | transperentcheck ne uporablja | transperentcheck uporablja |
| **Vrsta pripomočka, tudi ev. zdravljenje s kisikom**: .......................................................................... ....................................................................................................................................................... | | | |
| **Odvajanje:** | transperentcheck kontinenca | transperent   inkontinenca za urin | transperent  check inkontinenca za blato |
| transperentcheck Urinski kateter       Vrsta: .......................................................................................................... ....................................................................................................................................................... | | | |
| transperentcheck Stoma                    Vrsta: .......................................................................................................... ....................................................................................................................................................... | | | |
| **Stanje kože** (rane, razjeda zaradi pritiska, ...): ............................................................................ ....................................................................................................................................................... | | | |
| **Pomoč druge osebe:** | | transperentcheck ni potrebna | transperentcheck je potrebna |
| **Prehranjevanje:** | transperentcheck per os | transperentcheck hranjenje po NGS | transperentcheck hranilna stoma |
| **Dietna prehrana:** | | transperentcheck ni potrebna | transperentcheck je potrebna |
| Katera: ............................................................................................................................................ | | | |
| **Psihično stanje:** | transperentcheck orientiran/a | transperentcheck delno orientiran/a | transperentcheck ni orientiran/a |
| **Ali potrebuje nadzor:** | | transperentcheck da | transperentcheck ne |
| **MRSA:** | | | |
| **Ob premestitvi iz bolnišnice** | transperentcheck ne | transperentcheck da | transperentcheck preiskava ni bila opravljena |
| **Če biva doma** | transperentcheck ne | transperentcheck da | transperentcheck preiskava ni bila opravljena |
| **Druge posebnosti zdravstvenega stanja, ki so pomembne za izvajanje storitve:** ........................................................................................................................................................... ........................................................................................................................................................... ........................................................................................................................................................... | | | |
| **Drugo:** ........................................................................................................................................................... ........................................................................................................................................................... ........................................................................................................................................................... ........................................................................................................................................................... | | | |
| Podpis odgovorne medicinske sestre                    Žig:                            Podpis osebnega zdravnika:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Kraj in datum:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Soglašam s posredovanjem gornjih podatkov za potrebe uveljavljanja zdravstvenih in socialnovarstvenih storitev. | | | |