**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  | transperentcheck 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.  |