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| Bedarfsmeldung für KonsumentInnen von illegalen Substanzen und/oder Substituierten an das Beratungszentrum Pflege und BetreuungName der Einrichtung:Adresse:  |  |  |  | | --- | --- | --- | | **KlientIn:**  Name:  Adresse:    SVNR (inkl. Geb.Datum): |  | Angemeldet von:  Name:  Tel.Nr.:  E-Mail:  Datum: |  |  | | --- | | **Erforderliche Leistungen** |   Soziale Dienste (HH, HKP, BD,…)  Medizinische Hauskrankenpflege   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Entlassung** | | | | | | | | | | | | | | | Entlassungsadresse: |  | | | | | | | Telefon-Nummer: | | |  | | | | Patient kann Tür selbst öffnen: | |  | Ja | | |  | Nein | | | |  | |  | | |  | |  |  | | |  | Schlüssel bei: | | |  | | | | |  | |  |  | | |  | Schlüsselsafe, Code bei: | | |  | | | | | Geplante Entlassung (Datum/Uhrzeit): | | | |  | | | | | Ersteinsatz am: | | |  | | | **Diagnose** | | | | | | | | | | | | | | | Hausärztin/Hausarzt: | | | | |  | | | Telefon-Nummer: | | |  | | | | Substituierender Arzt | | | | |  | | | Telefon-Nummer: | | |  | | | | Diagnostizierte Betreuungsrelevante Erkrankungen (somatisch und psychisch) | | | | |  | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Infektionen: | | |  | | MRSA | | | | |  | Hepatitis | | | | | | | |  | | | HIV | | | | |  | | | | | | |  | | |  | | Sonstige: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | **Substitutionsmedikamente** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Substitution: | | | | | | | |  | | Ja | | | | | | |  | | | Nein | | | | | | | | | |  |  | | | BesorgungSubstitutionsmittel: | | | | | | | |  | | Selbständig | | | | | | |  | | | Hilfe nötig | | | | | | | | | |  |  | | | EinnahmeSubstitutionsmittel: | | | | | | | |  | | Selbständig | | | | | | |  | | | Hilfe nötig | | | | | | | | | |  |  | | | Aktuelles Rezept gültig zum Betreuungsbeginn: | | | | | | | |  | | Ja - bis | |  | | | | | | | | |  | | | Nein | | | | | |  |  | | | Mitgabe- und Abgaberegelungen | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | Abgebende Apotheke | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | Einschätzung der Stabilität | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | Anmerkungen (z.B. Beikonsum, Konsummuster, Applikationsform,…) | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |  | | --- | | **Weitere Medikamente** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Medikamentenvorbereitung | | | | | | | |  | | Selbständig | | | | | |  | | | Hilfe nötig | | | | | | | | | | |  |  | | | Medikamenteneinnahme | | | | | | | |  | | Selbständig | | | | | |  | | | Hilfe nötig | | | | | | | | | | | |  |  | | | | Verabreichung von Injektionen | | | | | | | |  | | Ja, welche: | | | | | |  | | | | | | | | | | | | | | | | |  | | **Umfeld** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | Lebt alleine | | | | | |  | |  | | | LebenspartnerIn: | | | | | | | | |  | | | | | | | Kontaktperson/  Angehörige: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Adresse: | | | |  | | | | | | | | | | | | | | | | | | | Telefon-Nummer: | | | | | |  | | | | | SachwalterIn/  Vertretungsbefugte: | | | Für folgende Belange: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Adresse: | | | |  | | | | | | | | | | | | | | | | | | | Telefon-Nummer: | | | | | |  | | | | |  | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | Über Entlassung verständigt wurde: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | **Pflegegeld / Pflegeheim** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Pflegegeld/Erhöhung/Klage | | | | | |  | Beantragt am: | | | | | | |  | | | | | | | | | | |  |  | | aktuelle PG-Stufe: | | |  | | | Pflegeheimantrag | | | | | |  | Gestellt am: | | | | | | |  | | | | | | | | | | |  | | | | | | | |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Mobilität** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | Selbständig | | |  | Rollstuhl | | | | | | |  | | | | | | Bettlägrig | | | | | | | | |  | | | | Gehhilfe: | | | | |  | | | | | | | | |  | | |  | | |  | Unterstützung beim Transfer erforderlich Anmerkungen: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Hilfsmittel / Heilbehelfe** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | vorhanden | | | | | | |  | | | | | erforderlich | | | | | | | | VO vorhanden: | | |  | | Ja |  | | | nein | | | |  | | | | | | | | | | | | |  | | | | | vorhanden | | | | | | |  | | | | | erforderlich | | | | | | | | VO vorhanden: | | |  | | Ja |  | | | nein | | | |  | | | | | | | | | | | | |  | | | | | vorhanden | | | | | | |  | | | | | erforderlich | | | | | | | | VO vorhanden: | | |  | | Ja |  | | | nein | | | | **Nahrung** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Besorgung: | | | | | |  | Selbständig | | | | | | | | |  | | | | | Hilfe nötig | | | | | | |  | | Anmerkung: | | | | | | | | |  | | | | | | | | | | | | | Zubereitung: | | | | | |  | Selbständig | | | | | | | | |  | | | | | Hilfe nötig | | | | | | |  | | Anmerkung: | | | | | | | | |  | | | | | | | | | | | | | Aufnahme: | | | | | |  | Selbständig | | | | | | | | |  | | | | | Hilfe nötig | | | | | | |  | | Anmerkung: | | | | | | | | |  | | | | | | | | | | | | | Insulinpflichtig: | | | | | |  | Ja | | | | | | | | |  | | | | | Nein | | | | | | |  | | Anmerkung: | | | | | | | | |  | | | | | | | | | | | | | Sondenernährung: | | | | | |  | Ja | | | | | | | | |  | | | | | Nein | | | | | | |  | | Anmerkung: | | | | | | | | |  | | | | | | | | | | | | | Essen auf Rädern: | | | | | |  | Ja | | | | | | | | |  | | | | | Nein | | | |  | | | Einsatzdatum: | | | | | | | | | | |  | | | | | | | | | | | | | Kostform: | | | | | |  | Normalkost | | | | | | | |  | | | | | Diätkost | | | | | | |  | | | | | Leichte Vollkost | | | | | | | |  |  | | | | | | | | | | | Anmerkung: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Körperpflege** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Waschen: | | | | | |  | Selbständig | | | | | | | | | | |  | | | | | Hilfe nötig | | | | | | | | | | | | | | | | | | | | | |  | | | An-/Auskleiden: | | | | | |  | Selbständig | | | | | | | | | | |  | | | | | Hilfe nötig Anmerkung: | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  |  | | | | | | | | | | |  | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | **Ausscheidungen** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Harn: | | | | | |  | Kontinent | | | | | | | | |  | | | | | | Inkontinent | | | | | | | | | | | | |  | | Dauerkatheter (BVK): | | | | | |  | | | | | |  | | |  | | | | | | | Anmerkungen: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Stuhl: | | | | | |  | Kontinent | | | | | | | | |  | | | | | | Inkontinent | | | | | | | | | | | | |  | | Stoma | | | | | | | | | | | | | | |  | | | | | | | Anmerkungen: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Hautzustand verändert: | | | | | | | |  | | Ja | | |  | | | | nein | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | Lokalisation: | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | Therapie & Frequenz: | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Einschränkungen** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | Sehen | | | |  | | Hören | | | | |  | | | | | | Sprechen | | | | | | | | | | | |  | | Orientierung | | | | | | | | | | | | | | | | Anmerkungen: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |      |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Sonstige pflege- und betreuungsrelevante Anmerkungen** | | | | | | | | | | | Weitere betreuende Einrichtungen: | | | |  | | | | | | |  | | Anmerkungen (wichtige Termine, Wohnungsadaptierung, etc.): | | | |  | | | | | | |  | | Haustiere: | | |  | Ja, welche: | | |  | | | | **Mitgegeben / KlientIn hat bei sich:** | | | | | | | | | | |  | | |  | Sozialbericht | | |  | Rezepte | |  | Verordnungsscheine | |  | | |  | PatientInnenbrief / Arztbrief | | |  |  | |  |  | |  | | |  | Medikamente - Welche: | | |  | | | | | |  | | |  | Substitutionsmedikamente | | |  | | | | | | **Kontaktdaten Beratungszentrum Pflege und Betreuung:** | | | | | | | | | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **bzP** | **Bezirke** | **E-Mail Adresse** | **Adresse** | **Tel** | **Fax** | | bzP NO | 1,2,20,21,22 | [beratungszentrum-no@fsw.at](mailto:beratungszentrum-no@fsw.at) | 1220 Wien,  Rudolf-Köppl-Gasse 2 | 01/ 24 5 24 | 05 05 379 / 99 / 60 590 | | | bzP SO | 3,11,4,5,10 | beratungszentrum-so@fsw.at | 1030 Wien, Guglgasse 7-9 | 01/ 24 5 24 | 05 05 379 / 99 / 60 290 | | bzP SW | 6,7,12,13,14,15,23 | [beratungszentrum-sw@fsw.at](mailto:beratungszentrum-sw@fsw.at) | 1150 Wien,  Graumanngasse 7/Stg.A/3.OG | 01/ 24 5 24 | 05 05 379 / 99 / 60390 | | | bzP NW | 8,9,16,17,18,19 | [beratungszentrum-nw@fsw.at](mailto:beratungszentrum-nw@fsw.at) | 1190 Wien, Heiligenstädter Straße 31/Stg.3 | 01/ 24 5 24 | 05 05 379 / 99 / 60 490 | | |