Patient questionnaire

Dear patient,

Thank you for your interest in our clinic. We have specialized in multiple sclerosis and related disorders and have developed an unique multimodal treatment concept.

We are in a quiet, natural environment, in the immediate vicinity of Lake Starnberg (300m) and would like to make your stay with us as pleasant as possible. The health and well-being of our patients and their special needs are our focus.

We have enclosed a questionnaire with this letter, which you can discuss with your doctor in advance. A direct statement from the doctor treating you makes it easier for us to comprehensively assess your clinical picture right from the start.

As a precaution, we would like to point out that the Marianne Strauß Clinic is a regular hospital for acute cases with multiple sclerosis or related disorders, so that the corresponding strict requirements for hospital treatment must be met. Exclusively rehabilitation treatment is not possible in our clinic.

The questions relate to your current state of health and the support you need for everyday activities.

Please have your doctor give you a briefing / referral and contact us to arrange an appointment for your inpatient stay.

Patient data

Last name: ____

First name: ____

Date of birth: ____

Street: ____

City, postcode: ____

Telephone: ____

E-Mail address: ____

Optional service/chief physician: yes ☐ no ☐

Single room: yes ☐ no ☐

Signature, Date: ____

Desired accommodation:
- ☐ Standard: Twin room
- ☐ Optional benefit: choice of doctor
- ☐ Optional benefit: single room

Basic price for single room: (ward 1A, 1B, 2C, 2D): 65,93 € per day

I have been treated at the Marianne-Strauß-Clinic before:

- ☐ yes
- ☐ no

Please bring copies of all medical reports and MRI scans with you.

Reports of previous and current examination results (all previous medical findings from the time of diagnosis and/or from the first suspected MS symptoms) e. g. from neurological examinations, cerebrospinal fluid puncture, magnetic resonance imaging (MRI); findings and images should be brought on CD-ROM or, if not available, on paper.

Please tick the appropriate box:

I use the following aids:

☐ Canes/crutches/walker

☐ Manual wheelchair

☐ Electric wheelchair

☐ Multifunctional wheelchair (care wheelchair)

☐ Splints/orthoses

Please be sure to bring the aids you need with you, as there are only a very limited numbers of devices available in the clinic!

Transfer (e.g. moving from bed <> wheelchair, wheelchair <> toilet):

☐ I can transfer independently

☐ I can transfer with difficulty alone

☐ I occasionally need help

☐ I always need help

Washing/dressing:

☐ I can wash and dress myself completely independently

☐ I need help with my legs (stockings, shoes, pants)

☐ I also need help with shirt/blouse/sweater/bra

☐ I need help with facial care (shaving, brushing teeth/hair)

☐ I need help with all personal hygiene

Meal:

☐ I can eat independently

☐ I need help with the preparation (cutting)

☐ The meal must be given to me by an assistant

☐ I choke more often when eating/drinking

☐ I have a feeding tube/percutaneous enteral gastrostomy

Bladder function:

☐ I have my bladder under control

☐ I need pads/urinal condoms

☐ I have an indwelling catheter/a suprapubic bladder fistula

☐ I regularly catheterize myself, catheters used: ________________________

☐ I am regularly catheterized by an assistant

Bowel movement:

☐ I have control over my bowel movements

☐ I have uncontrolled bowel movements

☐ I have to be taken away regularly

Orientation:

☐ I quickly find my way around in an unfamiliar environment

☐ I have difficulty finding my way in an unfamiliar environment

Please tick the health problems that are currently playing a major role for you and are therefore important for your stay in the clinic - if necessary together with your treating doctor

Please tick if applicable	**Problems**	**Description**	**Comments**
yes	Pain	If so, where?	
yes	Dysphagia	O for solid food O when drinking	
yes	Speech disorders		
yes	Shortness of breath		
yes	Forgetfulness Concentration problems		
yes	Depression		
yes	Sleep disorders		
yes	Weight loss		
yes	Pressure ulcers or other wounds		
yes	Seizures/epilepsy		
yes	Unrest		
yes	Serious domestic problems	What kind?	

There is a patient's provision

☐ no

☐ yes - please bring along!

There is a health care proxy

☐ no

☐ yes – please bring along

If yes, authorised representative is: Name ________________________________

address: ________________________________

Phone:________________________________

There is a legal guardianship

☐ no

☐ yes – please bring your carer´s card with you

If yes: is the legal guardian:

Name ________________________________

Address: ________________________________

____

Phone ________________________________

Signature patient/legal guardian: ____

Please tick as appropriate:

Would you like to have a conversations as a relative with

☐ Doctor

☐ Psychologist

☐ Social worker

☐ Chaplain

☐ Other: ______________________________

In person: ☐ on the day of admission

☐ during the inpatient stay

☐ on release

Or by telephone preferably between____________ and _______________

Please indicate telephone number or e-mail: ______________________________

<u>Please complete and return the clinic questionnaire and the findings/medical reports by e-mail or fax in advance</u>

Patient admission:

Email: aufnahme.patienten@ms-klinik.de

Fax: Nr. 0049-8151/261-263

Please have the referring doctor fill in the form:

Patient: ____

☐ **INPATIENT HOSPITAL TREAMTMENT IS REQUIRED**

Referral diagnosis:____

Other diagnoses: ____

Is MRSA- or ESBL- colonisation known?
If yes, where? Nose, throat, armpit, groin, urine______________________________________
Are the controls negative after therapy?
For patient from assisted living facilities/nursing homes, please include current swab results in order to avoid unnecessary isolation of the patient if necessary.

Reason for inpatient admission

☐ Confirmation of diagnosis

☐ Acute MS relapse with the following symptoms:______________________________________

☐ Deterioration in the last few weeks with problems/symptoms that cannot be treated on an outpatient basis (use attached table if necessary):______________________________
____

☐ Neuropsychiatric problems (e.g. depression, cognitive disorder)) ___________________

☐ Question on immunological therapy____

☐ Palliative care*____

**In MS, palliative therapy aims to enable the seriously ill to live a life worth living. It offers the most holistic individual treatment and care possible with accompaniment to alleviate physical complaints and support on a psychological and social level, among others.*

Referring doctor: (please give full address, telephone number and stamp):

Signature of referring physician______________________________

Please give your patient a copy of all relevant medical findings as well as MRI or X-ray images.