

MEDICAL INTAKE DOCUMENT



Date:	Name colleague:
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What happened?:

Name of patient:	M / F	length/cm:
Date of birth:	age:	weight/kg:

Patient hospitalized from:	to:	
Patient currently hospitalized in:		
Since:	<input type="radio"/> Normal Station	<input type="radio"/> ICU

Is patient stable:	<input type="radio"/> yes	<input type="radio"/> no		
Using oxygen:	<input type="radio"/> yes	<input type="radio"/> no	liters/min.:	
Is patient conscious:	<input type="radio"/> yes	<input type="radio"/> no		
Is patient mentally doing well:	<input type="radio"/> yes	<input type="radio"/> no – meaning:		
Is patient able to talk:	<input type="radio"/> yes	<input type="radio"/> no		
Is patient able to eat and drink:	<input type="radio"/> yes	<input type="radio"/> no		
Is patient able to walk:	<input type="radio"/> yes	<input type="radio"/> no	<input type="radio"/> wheelchair	<input type="radio"/> bedridden
Is patient paralysed:	<input type="radio"/> yes	<input type="radio"/> no	<input type="radio"/> left side	<input type="radio"/> right side
Did patient have surgery:	<input type="radio"/> yes	<input type="radio"/> no		
Does patient need surgery:	<input type="radio"/> yes	<input type="radio"/> no	<input type="radio"/> maybe	

Allergies (if known):
Medical history (other or older problems):

Relation between patient and contact person:		
Guiding passenger:		
Approval transport by doctor:	<input type="radio"/> yes	<input type="radio"/> no
Discharge medication:		
Medical report required:	<input type="radio"/> yes	<input type="radio"/> no

Patient needs to be hospitalized in:			
Patient already known in hospital:	<input type="radio"/> yes	<input type="radio"/> no	ward / Dr.:

Name contact person:
Home address:
Email address:
Telephone number:

Disclaimer:

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