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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:        |

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| **Erforderliche Leistungen** |

[ ]  Soziale Dienste (HH, HKP, BD,…) [ ]  Medizinische Hauskrankenpflege

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| **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)  |       |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| 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,…) |       |
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| **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: |       |  |

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| **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: |       |

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| **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:** |

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| --- | --- | --- | --- | --- | --- |
| **bzP** | **Bezirke** | **E-Mail Adresse**  | **Adresse** | **Tel** | **Fax** |
| bzP NO | 1,2,20,21,22 | 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 | 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 | 1190 Wien,Heiligenstädter Straße 31/Stg.3 | 01/ 24 5 24 | 05 05 379 / 99 / 60 490 |
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