Name der Einrichtung:

**🞎 Ambulante Dienste**

**🞎 Kirschblüte Gerresheim 🞎 Kirschblüte Wersten 🞎 WG Wohnen am Schloss**

**🞎 Tagespflege im Ernst- und Berta-Grimmke-Haus**

**🞎 Ernst- und Berta-Grimmke-Haus 🞎 Ernst- und Berta-Grimmke-Haus 3. OG**

**🞎 Georg-Glock-Haus 🞎 Hans-Jeratsch-Haus**

**🞎 Lore-Agnes-Haus**

**Aufnahmetermin:** 🞎 sofort 🞎 frühestens ab: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**Besuchstage Tagespflege:** **Mo** 🞎 **Di** 🞎 **Mi** 🞎 **Do** 🞎 **Fr** 🞎

**Kurzzeit- /Verhinderungspflege** von\_ \_ \_ \_ \_ \_ \_ \_ bis \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**Angaben zur gewünschten vollstationären Unterbringung**

🞎 nur Einzelzimmer

🞎 Einzel- oder Zweibettzimmer

**1. Angaben zur Person**

**Vor- und Zuname:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ **Geburtsname:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**Geburtstag:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_Geburtsort: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Familienstand: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ seit: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

#### Konfession/Religion: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Anschrift: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Telefon: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

E-Mailadresse: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Telefon: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**Derzeitiger Aufenthaltsort (falls von gemeldetem Wohnsitz abweichend):**

Wo?: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Straße: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

#### Postleitzahl/Ort: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Telefon (mit Vorwahl): \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**2. Ansprechpartner**

**Angehörige:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ **Adresse:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ **Telefonnummer:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**E-Mailadresse:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**Hausarzt:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

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**Fachärzte:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_\_ \_ \_ \_ \_

Sozialstation: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Essen auf Rädern: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Therapeuten: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**Besteht eine gesetzliche Betreuung oder Vorsorgevollmacht?** 🞎 ja 🞎 nein **wenn ja bitte angeben:**

Betreuungsgericht: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Aktenzeichen: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Art der Betreuung: 🞎 Aufenthaltsbestimmung

* Gesundheitsfürsorge
* Vermögensvorsorge
* Postverwaltung

Besteht eine Patientenverfügung? 🞎 ja (bitte mit einreichen) 🞎 nein

**Name des Betreuers:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Straße: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Postleitzahl/Ort: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Telefon (mit Vorwahl): \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

E-Mailadresse: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**3. Pflegekosten**

**Pflegegrad: 1** 🞎 **2** 🞎 **3** 🞎 **4** 🞎 **5** 🞎

**Pflegegrad beantragt** 🞎 ja 🞎 nein

Wenn ja wann? \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**Höherstufung beantragt** 🞎 ja 🞎 nein

Wenn ja wann? \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Information über die Pflegekosten/Aushändigung des Formblattes: 🞎

**Träger der Kosten:**

**Selbstzahler:** 🞎 ja 🞎 nein

**Pflegekasse:** 🞎 ja 🞎 nein

**Name/Adresse der Pflegekasse:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**Versichertennummer:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**Krankenkasse:** 🞎 ja 🞎 nein

**Name/Adresse der Krankenkasse:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**Versichertennummer:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

🞎 **Pflegewohngeld der Stadt:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Antragsdatum: \_ \_ \_ \_ \_ \_ \_

Sachbearbeiter/in: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

🞎 **Sozialamt der Stadt:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Antragsdatum: \_ \_ \_ \_ \_ \_ \_

Sachbearbeiter/in: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**Heimnotwendigkeitsbescheinigung liegt vor?** 🞎 ja 🞎 nein

Zusätzliche Betreuungsleistungen nach § 45: 🞎 ja 🞎 nein

Fürsorgestelle: 🞎 ja 🞎 nein

**Adressierung der Pflegerechnung:** \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

E-Mailadresse zum Rechnungsversand: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**Anlegung eines Barbetragskonto:** 🞎 ja 🞎 nein

Verwahrgeldvereinbarung ausgehändigt? Datum: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

- Ist der/die Antragsteller/in von den Rundfunkgebühren befreit?

🞎 ja 🞎 nein wenn ja, Angabe der GEZ-Nummer: \_ \_ \_ \_ \_ \_

- Besteht für den/die Antragsteller/in eine Befreiung von den Rezeptgebühren?

🞎 ja 🞎 nein wenn ja, Angabe der Befreiungs-Nr.: \_ \_ \_ \_ \_ \_

- Ist ein Schwerbehindertenausweis vorhanden?

🞎 ja 🞎 nein

**Information zum 1. Pflegetag/Aushändigung des Formblatts** 🞎 erfolgt

*Hinweis und Unterschrift*

Der Unterzeichner verpflichtet sich, die Einrichtung sofort zu unterrichten, wenn die Notwendigkeit zur Aufnahme nicht mehr besteht, z.B. wenn und sobald ein Pflegeplatz in einer anderen Einrichtung gefunden wurde. Er verpflichtet sich ferner,

die Notwendigkeit der Anmeldung in halbjährlichen Abständen telefonisch zu

bestätigen, da die Anmeldung ansonsten aus der Warteliste gelöscht wird.

Datum und Unterschrift des/der Anmeldenden

**4. Medizinische Daten**

Aktuelle Medikamentenverordnung und Diagnosen bei Einzug 🞎

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Allergien: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

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Verwaltung der Medikamente – Information Apotheke: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

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Aushändigung Medikamentenblatt: 🞎 erfolgt

Aushändigung Überleitungsbogen: 🞎 erfolgt

Bestätigung, dass keine ansteckenden und/oder meldepflichtigen Erkrankungen vorliegen 🞎 ja 🞎 nein

**5. Was bewegt Sie im Augenblick? Was brauchen Sie? Was können wir für Sie tun?**

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**6. Themenfelder**

Themenfeld 1 kognitive und kommunikative Fähigkeiten

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Themenfeld 2 Mobilität und Beweglichkeit

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Themenfeld 3 krankheitsbezogene Anforderungen und Belastungen

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Themenfeld 4 Selbstversorgung

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Themenfeld 5 Leben in sozialer Beziehung

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Themenfeld 6 Wohnen und Häuslichkeit

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**7. Wohlbefinden**

Welche Personen, Anlässe, Besitztümer, Gegebenheiten und Dinge machen den/die Interessent\*in zufrieden? \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Was tut ihm/ihr gut? \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

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Wobei fühlt er/sie sich wohl? \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

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