Beskydské rehabilitační centrum, s r.o.
Hlavní 42, 739 12 Čeladná IČ: 25868951 tel: +420 558 675 104
KOS Ostrava – Section C, Enclosure 23584 DIČ: CZ25868951

Application for rehabilitation treatment

.....	..... /	.....
Name and surname	Birth no.	Health Insurance Company

.....	.....	.....	.....
Street and No.	ZIP	Town	Phone

.....
Disablement NO/YES – since when

.....
Address/contact to the applicant or the organization ensuring the care of the patient's release

.....
Main rehabilitation diagnosis/operation type

Date of occurrence and brief description of affection:

.....

.....

.....

.....

Adjoining diagnosis/diet:

.....

.....

.....

Mobility:	walk – wheelchair - stairs	with support / without support /type individually / accompanied / electric wheelchair manages /does not manage / manages with difficulties

Decubiti: YES / NO Incontinence: YES / NO / sometimes

Compensation aids:

.....

Special requirements of the patient:

.....

.....

.....

INSTRUCTIONS

1. The physician providing recommendation of the patient shall be responsible for the correctness of information concerning his/her health condition.
2. The application must be COMLETELY filled in after its inclusion into the central record keeping.
3. The time of hospitalisation shall be determined by the physician providing treatment. The patient confirms with his/her signature to be taken over at the aforementioned contact address.

....

Date of issue of the Application

Signature and stamp of recommending physician

....

Patient's signature

Physician's tel.