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| Name |       | Zimmer |       |
| Vorname |       | Geburtsdatum |       |

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| Akute Diagnosen |
|       |

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| N**ebendiagnose**n |
|       |

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| **Besonderheiten der Krankengeschichte** |
|       |

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| **Allergien / Unverträglichkeiten** |
|       |

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| **Aktuelle Medikation, inklusive Salben, Inhalationen, Augentropfen** |
| **Medikament Dosierung** | **morgens** | **mittags** | **abends** | **nachts** |
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| **Reservemedikation** |
|  | **Einzeldosierung** | **Maximaldosierung** |
| **Schmerzreserve** | 1.
 | 1.
 |
|  | 1.
 | 1.
 |
| **Übelkeit** |       |       |
| **Fieber** |       |       |
| **Obstipation** |       |       |
| **Diarrhoe** |       |       |
| **Unruhe (Angstzustände)** |       |       |
| **Schlaflosigkeit** |       |       |
| **Individuelle Reserve(Blutdruck, Inhalation, etc.)** |       |       |
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| **Reanimation erwünscht** | [ ]  ja | [ ]  nein | [ ]  ungeklärt |
| **Patientenverfügung vorhanden** | [ ]  ja | [ ]  nein | [ ]  ungeklärt |

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| **Sterben / Verschlechterung** |
| [ ]  Hausarzt anrufen | auch nachts und am Wochenende: | [ ]  ja | [ ]  nein |
| [ ]  Notfallarzt anrufen |

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| **Bemerkungen** |
|       |

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| Name Hausarzt |       |
| Datum |       | Unterschrift Arzt |       |