MS.AD.18A Rev. 11 Ottobre 2025 Pagina 1 di 2	DIREZIONE SANITARIA	Fondazione Don Carlo Gnocchi ONLUS Area Territoriale Centro CENTRO "E. BIGNAMINI" Via Matteotti, 56 – 60015 Falconara (AN)

QUESTIONNAIRE FOR ASSESSING SUITABILITY FOR ACCESS TO REHABILITATION TREATEMENTS FOR OUTPATIENTE AND HOME PATIENT

Surname _____ **Name** _____

Fiscal Code _____ (*please attach a copy of your health insurance card*)

Phone: _____ E-mail: _____

Date of birth _____ Place of birth _____

Municipality of residence_____Street_____

Address/city of domicile (if different from residence)

_____

Questionnaire for assessing suitability for access to rehabilitation treatments *(the form must be fully completed, incomplete questionnaires will not be accepted).*

1) **Sent by**: *(Please select one and provide the referring doctor's name)*

- ☐ **GP (General Practiotioner)** _____
- ☐ **Pediatrician** _____
- ☐ **Specialist** *(insert type)* _____

2) Diagnosis_____

_____

Date of onset _____

Date of operation (if applicable): _____

3) Do you have a civil disability? YES ☐ _____ % NO ☐

Compiling date _____

Compilazione a cura del Centro:

Firma segreteria _____ Data _____

Valutazione medico: convenzione ☐ privato ☐

urgente: SI ☐ NO ☐

visita di 60' ☐ 30' ☐

Firma medico _____ Data _____

Visita prenotata con il dr. _____ il _____

Note _____

_____

_____

Below you will find a list of everyday activities. We ask you to select with an X the answer that best represents your situation.

Description of activities	Not able	Needs help	Alone but with some difficulties	Autonomous
FEED	☐	☐	☐	☐
HAVE A BATH/A SHOWER	☐	☐	☐	☐
TAKE CARE OF OUTER APPEARANCE (wash your face, comb your hair, brush your teeth, shave, etc.)	☐	☐	☐	☐
GETTING DRESSED	☐	☐	☐	☐
INTESTINE CONTROL	☐	☐	☐	☐
BLADDER CONTROL	☐	☐	☐	☐
USING THE TOILET (sitting down, getting up, cleaning yourself, getting dressed)	☐	☐	☐	☐
TRANSFERS (from sitting on the bed to the chair and vice versa)	☐	☐	☐	☐
WALKING (on flat and regular surfaces)	☐	☐	☐	☐
TAKING THE STAIRS	☐	☐	☐	☐

Please indicate any other pathologies/surgeries/fractures you suffer from:

_____
_____
_____
_____

Have you been hospitalized in the last 12 moths? YES ☐ NO ☐

Date of last hospitalization: _____

Have your problems worsened in the last 12 months? YES ☐ NO ☐

Patient signature _____

Users are informed that it is not permitted to perform National Health Service services at this Center at the same time as other public or accredited facilities.

Patient signature for acknowledgment _____

Attach to this request the copy of the health insurance card and the consent form for the processing of personal and sensitive data as required by EU Regulation 679/2016.