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| **ＮＩＣＵ後方病床連絡票** | | | | | | | | | | | | | 記入日 | | |  | | | | | | | 年 | |  | | | | 月 | | |  | | 日 | |
| 依頼元病院名  （診療科）主治医 | | |  | | | | | | | | | | | | | | | 連絡を取った  当院医師（有・無） | | | | | | | | | |  | | | | | | | |
| 患者 | フリガナ |  | | | | | | | | | 生年月日 | | |  | | | | 年 |  | | | | | 月 |  | | 日 | | | | 性別 | |  | | |
| 氏名 |  | | | | | | | | |
| 住所 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 基礎疾患 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 主な合併症 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 心疾患の有無  現在の状況 | | 有　　　無 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 出生時の状況  その後の経過 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 現在の治療 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 身長 | |  | | | | cm | | 体重 | | |  | | | | kg | | | 自発運動 | | | | | | | | 有　　無 | | | | | | | |
| 患者の状態 | | 睡眠／覚醒リズム | | | | | | | 有　　無　　不明 | | | | | | | | けいれん | | | | | | | | | 有　　　無 | | | | | | | | | |
|  | | 筋緊張 | | | | | | | 亢進　　正常　　低下 | | | | | | | | 変形・拘縮 | | | | | | | | | 有　　　無 | | | | | | | | | |
| 処置の内容 | | 呼吸器使用 | | | | 有　　無 | | | | | | 気管切開 | | | 有　　無 | | | | | | | 胃ろう | | | | | | | | 有　　無 | | | | | |
| 栄養方法・内容 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 症状の安定度 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 当院への  転院目的  （具体的に記載してください） | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 家族構成  （キーパーソン） | | | ・疾病のある家族は記入　・キーパーソンと思われる人に※をつけてください | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| これまでの在宅移行への指導状況  （吸引・カニューレ交換など具体的に） | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 現在利用している公的サービス  （児相の関わり・手帳の有無・  産科医療補償制度の申請など） | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| これまでの家族の面会状況や  病院に対する要望・要求 | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 在宅移行に向けての問題点 | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 転院目的の家族への説明内容 | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 転院に対する家族の受け止め  （家族が当院に期待していることや転院に対する理解度） | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ご連絡先 | | 担当者氏名 | | |  | | | | | | | | | | （ 職種 | | | | | |  | | | | | | | | | | | | ） | |
| 電話 | | |  | | | | | | | | | | ＦＡＸ | | | | | |  | | | | | | | | | | | | | |