

APPLICATION FORM (continued)

2. Patient details (continued)

Epilepsy: a) number of fits per month _____

b) treatment (medications) _____

Recent X-ray of the hips (6 months), medical report: _____

Heart disease: _____ Scoliosis: _____

Diabetes: yes no

Hydrocephalus: yes no

Tracheostomy/G-Tube: _____

Shunts: yes no

Visual and auditory ability:

Medications currently taken, purpose:

Physical abilities (e.g. crawling, walking, sitting, etc.):

Allergies: _____

Equipment used (e.g. walker, crutches, canes, etc.): _____

I have read and agree with the General Terms and Conditions of the ADELI Rehabilitation Center.

Date _____

Signature _____

*Please fill out the form and fax to the ADELI Center:
Fax number ++ 421 33 77 18 108*