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| Avenue Vinet 30 | Tél. Clinique | +41 (0)21 641 33 33 | |
| 1004 Lausanne | Tél. réservation | +41 (0)21 641 33 77 | |
| Suisse | Fax réservation | +41 (0)21 641 34 37 | |
|  | reservations@lasource.ch | |  |
|  |  | | |
| **Conﬁrmation de demande d’admission** | | | |
| (A faire parvenir par Email ou par fax au Service des réservations) | | | |

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| **Date d’entrée:** | **Heure :** |
| **Durée de séjour:** | |
| ☐ Hospitalisation | |
| ☐ Ambulatoire | |
| **Prestation complémentaires** | |
| ☐ **La Source à domicile :** | |
| ☐ Visites et soins infirmiers (joindre prescription médicale) | |
| ☐ Autres: | |

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| **Patient** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nom du médecin: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nom du patient: | | | | | |  | | | | | | | | | | | | | | | | Prénom : | | | | |  | | | | | | | Sexe: M ☐ F ☐ | | | |
| Date de naissance: | | | | | | |  | | | | | | | | | | | | | | | Profession: | | | | |  | | | | | | | Etat-civil: | |  | |
| Adresse: | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| N° postal: | | |  | | | | | | | | | | | | Lieu : | |  | | | | | | | | | | | | | | | | | | | | |
| Tél. privé: | | |  | | | | | | | | prof.: | |  | | | | | | | Portable: | | | | |  | | | | Tél. parenté: | | | | |  | | | |
| Employeur : | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | N° accident: | | | | |  | | | |
| Nom + N° de l’assurance de base: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | Maladie☐ | | | | Accident ☐ | | | Maternité ☐ | |
| Nom + N° assurance complémentaire: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | **Catégorie: P** ☐ | | | | | | **SP** ☐ | | **CC** ☐ |
| Sans assurance (dépôt) Frs: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | Souhaits chambre | | | | | | P ☐ | | SP ☐ |
| **Diagnostics et motif d’hospitalisation (CIM)** Principaux & secondaires y.c. comorbidités  (Merci de nous indiquer les codes CIM) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Lettre ou dossier médical du médecin traitant ☐ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Intervention(s) (CHOP)**  (Merci de nous indiquer les codes CHOP) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Voie d’abord: Tomie ☐ Scopie ☐  **Préparation à l’intervention** (si différent du schéma habituel de l’opérateur) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Instruments et matériels spéciﬁques:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Installation du patient:** | | | | | | | | | | | | | | | | | | | | | ☐ **Ampliﬁcateur de brillance** ☐ **O-Arm** ☐ **Robot** | | | | | | | | | | | | | | | | |
| Date : |  | | | | | | | | Heure: | | |  | | | | | | | | | Durée: | | | | |  | | | | | heure(s) | | |  | | | |
| Soins intensifs: | | | | |  | | | | nuit(s) | | | |  | | | | | | | |  | | | | |  | | | | |  | | |  | | | |
| Anesthésie: générale ☐ | | | | | | | | | péridurale ☐ | | | | | | | | | | | | ☐ Risque **PRION\*:** non ☐ oui ☐ | | | | | | | | | | | | | | | | |
| Allergies: | | | latex ☐ | | | | | | iode ☐ | | | | |  | | | | | | | HIV ☐ | | | | | | Hépatite ☐ | | | | | MRSA ☐ | | Autres ☐ | | | |
| **Examens** (ont été faits oui ☐) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mode d’acheminement au Service des réservations: | | | | | | | | | | | | | | | | | | par Email ☐ | | | | | | | | courrier ☐ fax ☐ | | | | | | | | autre ☐ | | | |
| Laboratoire : | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Groupe Rh.: oui ☐ non ☐ | | | | | | | | | Sang : | | | | | | |  | | | | | | | | ﬂacon(s) | | | | | | Autotransfusion: oui ☐ non ☐ | | | | | | | |
| ECG: oui ☐ non ☐ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Radiologie: Radiographie du thorax: oui ☐ non ☐ | | | | | | | | | | | | | | | | | Autres : | | | | | | |  | | | | | | | | | | | | | |
| Suivi diététique post op.: oui ☐ non ☐ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Physiothérapie: ☐ Pré-op: | | | | | | | |  | | | | | | | | | | | ☐ Post-op.: | | | | | | | | | ☐ Sortie CLS: | | | | | | | | | |
| *\* Symptômes SNC progressifs, anamnèse familiale positive, injections hormones de croissance ou opération sur le SNC avant 1995* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Médecin: | | | | | | | | | | | | | | | | | | | | | | | Date: | | | | | | | | | | |

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