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SURVEY FORM

Patient Details						
Name:		Date of Birth:				
Address:		Gender		Male <input type="checkbox"/>	Female <input type="checkbox"/>	
Postcode:		Telephone No.				
GP Address		Next of Kin				
		Address				
Telephone No.		Telephone No.				
		Relationship				
Current Medical Conditions						
Previous Medical History						
Risks and Precautions (eg. falls, DNACPR)			Allergies			
Social Situation						
Lives with:		Spouse <input type="checkbox"/>	Relative <input type="checkbox"/>	Partner <input type="checkbox"/>	Alone <input type="checkbox"/>	Other <input type="checkbox"/>
Accommodation Details						
Bungalow <input type="checkbox"/>	House <input type="checkbox"/>	Flat/floor <input type="checkbox"/>	Own <input type="checkbox"/>	Private Rent <input type="checkbox"/>	Other <input type="checkbox"/>	
Central Heating: oil / gas / electric <input type="checkbox"/>		Fire: electric / gas / coal <input type="checkbox"/>		Cooker: electric / gas <input type="checkbox"/>		
Microwave: <input type="checkbox"/>		Telecare: falls detector, bed sensor <input type="checkbox"/>		Smoke detector: <input type="checkbox"/>		
Access						
Front steps / number <input type="checkbox"/>		Rear steps / number <input type="checkbox"/>		Internal stairs Yes <input type="checkbox"/> No <input type="checkbox"/>		
Ceiling lift <input type="checkbox"/>		Stair lift <input type="checkbox"/>		Community Alarm Yes <input type="checkbox"/> No <input type="checkbox"/>		
Internal layout						
Bedroom $\uparrow\leftarrow\rightarrow\downarrow$		Bath $\uparrow\leftarrow\rightarrow\downarrow$		Toilet $\uparrow\leftarrow\rightarrow\downarrow$		
Shower $\uparrow\leftarrow\rightarrow\downarrow$		Cubicle <input type="checkbox"/>	Over Bath <input type="checkbox"/>	Wet Room <input type="checkbox"/>		
Functional Abilities						
Hearing			Vision			
Speech			Cognition			

