



HEALTH FORM

to be filled and sent by email exclusively to Dr. Francesco Morandi

<morandifrancesco55@gmail.com>

PART I – HEALTH STATUS																								
Participant’s full name																								
Date of birth																								
Medical diagnoses																								
Genetic diagnosis																								
Current general health conditions																								
Regular therapies to be continued during the camp																								
<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="padding: 5px;"><i>Drug</i></th> <th style="padding: 5px;"><i>Dose</i></th> <th style="padding: 5px;"><i>Route of administration</i></th> <th style="padding: 5px;"><i>Days / times</i></th> <th style="padding: 5px;"><i>Notes</i></th> </tr> </thead> <tbody> <tr><td style="height: 20px;"></td><td></td><td></td><td></td><td></td></tr> <tr><td style="height: 20px;"></td><td></td><td></td><td></td><td></td></tr> <tr><td style="height: 20px;"></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>					<i>Drug</i>	<i>Dose</i>	<i>Route of administration</i>	<i>Days / times</i>	<i>Notes</i>															
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Is the participant independent in administering these therapies yes <input type="checkbox"/> no <input type="checkbox"/>																								
Notes																								
Therapies to be administered only if needed																								
Is the participant independent in administering these therapies yes <input type="checkbox"/> no <input type="checkbox"/>																								
Has the participant ever had seizures? yes <input type="checkbox"/> no <input type="checkbox"/> Date of most recent event																								
Circumstances (<i>stress, sensory stimulation, etc.</i>)																								
Notes																								
Cognitive difficulties? yes <input type="checkbox"/> no <input type="checkbox"/>																								
Notes																								
Sensory difficulties? yes <input type="checkbox"/> no <input type="checkbox"/>																								
Notes																								
Difficulties with walking or balance? yes <input type="checkbox"/> no <input type="checkbox"/>																								
Notes																								

PART II – VENTILATION MANAGEMENT																							
Type of ventilation used during the camp invasive (tracheostomy) <input type="checkbox"/> non-invasive (mask) <input type="checkbox"/> diaphragmatic pacemaker <input type="checkbox"/>																							
Do you have a diaphragmatic pacemaker, even if you will not use it during the camp? Yes <input type="checkbox"/> no <input type="checkbox"/>																							
Do you have a cardiac pacemaker? yes <input type="checkbox"/> no <input type="checkbox"/>																							
Brand		Model																					
Tracheostomy																							
yes <input type="checkbox"/> No <input type="checkbox"/> Cannula model																							
		Size																					
Will you have an emergency replacement kit available during the camp? yes <input type="checkbox"/> No <input type="checkbox"/>																							
Do you require suctioning of airway secretions?																							
<table border="1" style="margin: auto; border-collapse: collapse;"> <thead> <tr> <th style="padding: 5px;"><i>When</i></th> <th style="padding: 5px;"><i>yes</i></th> <th style="padding: 5px;"><i>no</i></th> <th style="padding: 5px;"><i>sometimes</i></th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">Morning</td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 5px;">During the day</td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 5px;">Evening</td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 5px;">During the night</td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/></td> </tr> </tbody> </table>				<i>When</i>	<i>yes</i>	<i>no</i>	<i>sometimes</i>	Morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	During the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	During the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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During the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
Notes																							
Oxygen therapy																							
Do you require oxygen therapy? yes <input type="checkbox"/> no <input type="checkbox"/> sometimes <input type="checkbox"/>																							
In which situations?																							
Ventilation device																							
Brand		Model																					
Battery type internal <input type="checkbox"/> external <input type="checkbox"/>																							
Humidifier type internal <input type="checkbox"/> external <input type="checkbox"/> not used <input type="checkbox"/>																							
Ventilation parameters set as fixed values yes <input type="checkbox"/> no <input type="checkbox"/>																							
Ventilation parameters adjusted depending on the situation yes <input type="checkbox"/> no <input type="checkbox"/>																							
Note																							
Monitoring																							
I use an O ₂ saturation monitoring device during the night yes <input type="checkbox"/> no <input type="checkbox"/>																							
O ₂ saturation alarm threshold setting																							
I use a CO ₂ monitoring device yes <input type="checkbox"/> no <input type="checkbox"/>																							
CO ₂ alarm threshold setting																							
Additional useful information for the care team																							

If the participant is supported at home by home-care services, please attach a copy of the care plan or a transfer report to the registration.



With this document, we authorize Dr. Francesco Morandi to obtain any medical information necessary for the complete care of the patient, and to take care of the patient in case of non-deferrable need (for minors, the signature of parents or legal guardians is required).

Name, surname, and signature of the participant or of the parent/guardian if the participant is a minor.

Name / Surname _____

Date _____

Signature _____

Please remember that this **HEALTH FORM** must be sent by email only to Dr. Francesco Morandi at morandifrancesco55@gmail.com