Załącznik nr 11b do zarządzenia nr 101/2025/DSOZ  
Prezesa Narodowego Funduszu Zdrowia  
z dnia 23 grudnia 2025 r.

**Karta całościowej oceny geriatrycznej**

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| Nazwisko i imię ………………………………………………............ | | | | | | | | | | | | | | | | | | | PESEL ………………… | | | | |
| Data badania ………… | | | Ilość lat edukacji ……… | | | | | | | | | | | Adres i tel. ośrodka kierującego ...……. | | | | | | | | | |
| …………………………………………………………………………………………………….….... | | | | | | | | | | | | | | | | | | | | | | | |
| Wymagane noszenie: | | | | okularów Tak /Nie, | | | | | | | | | aparatu słuchowego Tak/ Nie | | | | | | | | | | |
| Realizowane noszenie: | | | | okularów Tak/ Nie, | | | | | | | | | aparatu słuchowego Tak/ Nie | | | | | | | | | | |
| Opiekun……………………………………… | | | | | | | | | | | Stopień pokrewieństwa……………………….. | | | | | | | | | | | | |
| Adres …………………………………………………….....…......................... | | | | | | | | | | | | | | | | | | | | | Tel ………….... | | |
| Reaktywna sytuacja stresowa do 2 lat wstecz: Nie/ Tak ( utrata roli zawodowej/rodzinnej, utrata bliskiej | | | | | | | | | | | | | | | | | | | | | | | |
| osoby, nieuleczalna choroba, nie leczony stan bólowy, narkoza, samotność, inne..............................….) | | | | | | | | | | | | | | | | | | | | | | | |
| Stan skóry………………………………… | | | | | | | | | | Ograniczenie ruchomości……………………............. | | | | | | | | | | | | | |
| Przebyte złamania kości ( od 60 r. ż.) lokalizacja……………………………………………………..... | | | | | | | | | | | | | | | | | | | | | | | |
| Waga ...kg, | Wzrost...cm | | | | Obwód ramienia...cm, | | | | | | | | | | | Obwód podudzia…cm, | | | | | | Obwód talii ...cm, | |
| Test.BERG\*/skrócony Tinetti…………… | | | | | | | | Zalecenia odnośnie aktywności | | | | | | | | | | | | | | | |
| ruchowej/chodu…………………………………………………………………………………………… | | | | | | | | | | | | | | | | | | | | | | | |
| ……………………………………………………………………………………………………………… | | | | | | | | | | | | | | | | | | | | | | | |
| Nietrzymanie moczu: Tak/Nie, | | | | | | jeśli Tak: naglące Tak/Nie | | | | | | | | | | | | | | wysiłkowe: Tak/Nie | | | |
| Odleżyny: Nie/Tak- Lokalizacja …………………… | | | | | | | | | | | | | | | Skala BRADEN/ Norton ………………… | | | | | | | | |
| Indeks BARTHEL pkt………./ADL\*……… | | | | | | | | | | Skala IADL…………………………………………… | | | | | | | | | | | | | |
| 15 pkt. Geriatryczna Skala Oceny Depresji........ | | | | | | | | | | | | Skala MMSE\*, Norma oczekiwana….......Wynik … | | | | | | | | | | | |
| Uwagi …………………….....................................................................................................................… | | | | | | | | | | | | | | | | | | | | | | | |
| ………………………………………………………………… | | | | | | | | | | | | | | | | | | Test Rysowania Zegara ………./5pkt. | | | | | |
| Inne testy\*…………………………………………………………………………………………………… | | | | | | | | | | | | | | | | | | | | | | | |
| Uzależnienie od leków Tak/Nie…………………………… | | | | | | | | | | | | | | | | | Jatrogenny zespół geriatryczny | | | | | | |
| …………………………………………………………… | | | | | | | | | | | | | | | | Przebyty TIA: Tak/Nie | | | | | | Udar: Tak/Nie | |
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|  | | **Parametry o znaczeniu rokowniczym** | | | | | | | | | | | | | | | | | | | | |  |
| **Utrata masy ciała >6kg/6 lub 3kg/ 3 m-ce** | | | | | | | | | **Stwierdzana wartość……………………** | | | | | | | | | | | | | |  |
| **Hyponatremia < 135 mmol/L** | | | | | | | | | **Stwierdzana wartość……………………** | | | | | | | | | | | | | |  |
| **Hypoalbuminemia < 3,7 g/dL** | | | | | | | | | **Stwierdzana wartość……………………** | | | | | | | | | | | | | |  |
| **Hemoglobina <12%** | | | | | | | | | **Stwierdzana wartość……………………** | | | | | | | | | | | | | |  |
| **Limfopenia<1200µl3** | | | | | | | | | **Stwierdzana wartość……………………** | | | | | | | | | | | | | |  |
| **CRP> 6 mg/L** | | | | | | | | | **Stwierdzana wartość……………………** | | | | | | | | | | | | | |  |
| **pO2<60 mmHg\*** | | | | | | | | | **Stwierdzana wartość……………………** | | | | | | | | | | | | | |  |
| **Klirens kreatyniny < 35 ml/min** | | | | | | | | |  | | | | | | | | | | | | | |  |
| **Hipotonia ortostatyczna Tak/nie** | | | | | | | | | **Wynik test z L-DOPA\*> 20%............** | | | | | | | | | | | | | |  |
| **Glikemia na czczco 2x> 100 mg%** | | | | | | | | | **Epizody hipoglikemii Tak/Nie** | | | | | | | | | | | | | |  |
| **Wynik TSH………………. Wynik B12\*** | | | | | | | | | **Prawidłowy/ Nieprawidłowy** | | | | | | | | | | | | | |  |
| **\*opcjonalnie** | | | | | | |  | | | | | | | | | | | | | | | |  |
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**Wnioski diagnostyczne/lecznicze:**

**………………………………………………………………………………………………………………**

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**Zalecenia lekarza geriatry:**

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|  | .................................................. |
|  | Nadruk lub pieczątka zawierająca imię  i nazwisko, numer prawa  wykonywania zawodu oraz podpis  lekarza |