First Rett Aid

Ingevuld af te geven aan het medisch personeel bij ziekenhuisopname

Name:

Date of birth:

Name and telephone number general practitioner:

Name and telephone number other doctors:

PART 1 BASIC INFO

Age: Length: Weight:

Current medication:

Known allergies:

Preferred blood sampling spot: elbow-crease hand foot

In pain: shouting crying gritting teeth hitting lethargic other:

Nutrition: normal blended stomac-pump remarks:

Can she communicate? yes no if yes, how:

Can she walk? yes no

Can she use her hands? yes no

Does she eat independently? yes no

Is she potty trained? yes no

Rett syndrome related problems

Respiratory disorders? yes no if yes, specify:

Scoliosis or kyphosis? yes no if yes, gradation:

Sleeping disorders? yes no if yes, specify:

Epilepsy? yes no

Reflux? yes no

Swallowing problems? yes no

Gritting one's teeth or bruxism? yes no

Constipation? yes no

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PART 2 PREVIOUS HOSPITALIZATIONS

Per hospitalization please note down: date, cause, symptoms, treatment, name and telephone number hospital, name and telephone number treating doctor(s)

Was she intubated? yes no

Tracheotomy? yes no

Swollen pharyngeal mucosa at operations? yes no

PART 3 IN CASE OF EPILEPSY

Current epilepsy treatment + dose:

Latest EEG, date and result:

PART 4 IN CASE OF PNEUMONIA

Latest lung radiography, date and result:

Oxygen saturation:

Oxygen treatment at home? yes no

Oxygen tolerance? yes no

Apnea? yes, at night yes, during the day no

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