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| **Therapie- und Dokumentationsplan** | | | | | | | | | | | | | | | | | | **BGSW-Klinik:** | | | | | | […] | | | | | | |
| **Berufsgenossenschaftliche Stationäre Weiterbehandlung (BGSW)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Unfalltag: | | […] | | | | | | | | | | | | | | | Diagnose: | | […] | | | | | | | | |
|  | | | Aufnahmetag: | | | | […] | | | | | | | | | | | | | Belastung: | | | […] | | | | | | | |
|  | |  | BGSW-Plan von: | | | | | | | […] | | | bis: | | | […] | | | | Ziel der BGSW: | | | | | | […] | | | | |
| Pat.-Aufkleber | |  | Entlassung voraussichtlich am: | | | | | | | | | […] | | | | | | | |  | | | | | | […] | | | | |
|  | |  | Entlassung bereits erfolgt am: | | | | | | | | | […] | | | | | | | | Besonderheiten: | | | | | | […] | | | | |
|  | |  | Verantwortliche/r | | | | | |  | | | | | | | | | | |  | | | | | |  | | | | |
|  | | | Therapeut/in: | | | | | | […] | | | | | | | | | | |  | | | | | | […] | | | | |
|  | | | Unterschrift der Chefärztin/des Chefarztes: | | | | | | […] | | | | | | | | | | | Versicherte Person kann nach der BGSW voraussichtlich ihre/seine bisherige Tätigkeit wieder aufnehmen:   ja  nein | | | | | | | | | | |
|  | | | | | | | | (Datum) | | | | | | | (Unterschrift) | | | | | | | | | | | | | | | |
| Behandlungstag (Datum): | […] | […] | | […] | | […] | | | | | […] | | | […] | | | […] | | […] | | […] | | | | […] | | […] | […] | […] | […] | |
| Therapiemaßnahme: (KTL) | Min.: \* | Min.: \* | | Min.: \* | | Min.: \* | | | | | Min.: \* | | | Min.: \* | | | Min.: \* | | Min.: \* | | Min.: \* | | | | Min.: \* | | Min.: \* | Min.: \* | Min.: \* | Min.: \* | |
| […] | […] | […] | | […] | | […] | | | | | […] | | | […] | | | […] | | […] | | […] | | | | […] | | […] | […] | […] | […] | |
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| […] | […] | […] | | […] | | […] | | | | | […] | | | […] | | | […] | | […] | | […] | | | | […] | | […] | […] | […] | […] | |
| Unterschrift der versicherten Person:  (Ich bestätige die Therapie- maßnahmen und deren Dauer) |  |  | |  | |  | | | | |  | | |  | | |  | |  | |  | | | |  | |  |  |  |  | |
| \* Bitte Therapiedauer in Minuten angeben!  Bitte Plan sofort nach Abschluss der 14-tägigen Behandlung dem zuständigen Unfall- versicherungsträger übersenden! Für weitere Behandlung bitte neuen Plan verwenden! | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |