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| **Anmeldung Sonografie** |
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| Name | ...................................................... | Geburtsdatum | ...................................................... |
| Vorname | ...................................................... | Telefon | ...................................................... |
| Adresse | ...................................................... | Mobile | ...................................................... |
| PLZ/Ort | ...................................................... | Garant | ...................................................... |
|  |
| [ ]  Patient/-in aufbieten |
| [ ]  Sonografie vereinbart für den ............................................................................................................ |
| [ ]  Erstuntersuchung | [ ]  Verlaufsuntersuchung |
|  |
| [ ]  Diagnostik / Sonografie-Interpretation |
| [ ]  Diagnostik / Sonografie-Interpretation sowie Konsilium (empfohlen) |
|  |
| Sonografie gewünscht durch | [ ]  Dr. med. Gion Caliezi[ ]  Dr. med. Barbara Meyer[ ]  Dr. med. Florian Winkler[ ]  Dr. med. Caroline Moser | [ ]  Dr. med. Véronique Grobéty[ ]  offen |
|  |
| **Region**  |
| ................................................................................................................................................................. |
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| **Anamnese, Verdachtsdiagnose, Fragestellung** |
| ..................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................... |
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| **Aktuelle Medikation**  |
| .................................................................................................................................................................................................................................................................................................................................. |
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| **Bemerkungen** |
| .................................................................................................................................................................................................................................................................................................................................. |
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| Datum:       | Unterschrift/Stempel:       |