SNRI

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Specialist doctor FMH
Radiology & Neuroradiology
Prof. Dr. med. Isabel Wanke
Prof. Dr. med. Daniel Rüfenacht

Specialist doctor FMH
Radiology Dr. med. Beat
Porcellini

Medical Imaging Registration Form

Personal Details

Name: Street:

First name: PC,City:

Date of birth: Phone:

Gender: ☐ M ☐ F ☐ Divers

Cost unit

☐ Health insurance ☐ Accident ☐ Self-payer

Insurance: Vers. no.

Order Specific Data

Requested examination / treatment

☐ MRI ☐ CT ☐ Infiltration

Body region:

Clinical data, research question:

Allergies: Creatinine level:

Implants: ☐ no ☐ yes

Pacemaker: ☐ no ☐ yes Pregnancy: ☐ no ☐ yes

☐ Call patient ☐ Patient already has an appointment :

Assigner

☐ Quick Report

Report: ☐ Portal ☐ E-Mail ☐ Post

Images: ☐ Portal ☐ CD ☐ keine

Copie of report to:

Doctor :

Surname/first name:

Phone / Mobile:

E-Mail-Adresse: Date:

The patient has consented to the processing and storage of data in accordance with the Data Protection Law. This also includes the purposeful disclosure of the data to third parties.