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Radiology & Neuroradiology
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Specialist doctor FMH
Radiologie
Dr. med. Beat Porcellini

Registration Form Second Assessment / Consil for previous carried out radiological examinations

Personal Details	Surname:	Street:
	Firstname:	PC, City:
	Date of birth:	Phone :
	Cost unit ☐ Health Insurance ☐ Accident ☐ Self-payer	
	Insurance:	Vers. No.

Order Specific Data	Medical examination to be assessed ☐ CT ☐ MRI	Where was the examination carried out?
	Body region:	
	Clinical data, research question:	
	Remark :	
	☐ Call Patient for a consultation appointment ☐ Patient already has a consultation appointment on:	

Assigner	Copie of report to:	
	Doctor :	
	Surname/Firstname:	
	Phone / Mobile:	
	E-Mail-Adresse:	Date: