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Dr. med. Johannes Weber

Specialist doctor FMH
Radiologie
Dr. med. Beat Porcellini

Registration Form Second Assesment / 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:

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.