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| **Anmeldung rheumatologisches Konsilium**  |
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| Name | ...................................................... | Geburtsdatum | ...................................................... |
| Vorname | ...................................................... | Telefon | ...................................................... |
| Adresse | ...................................................... | Mobile | ...................................................... |
| PLZ/Ort | ...................................................... | Garant | ...................................................... |
|  |
| [ ]  Patient/-in aufbieten |
| [ ]  Untersuchung vereinbart für den ....................................................................................................... |
| [ ]  Erstuntersuchung | [ ]  Verlaufsuntersuchung |
| [ ]  regulär | [ ]  dringlich (keine spezifische Arztzuteilung) |
|  |
| Konsilium gewünscht durch | [ ]  Dr. med. Jürg Suter[ ]  Dr. med. Gion Caliezi[ ]  Dr. med. Barbara Meyer[ ]  Dr. med. Florian Winkler[ ]  Dr. med. Caroline Moser | [ ]  Dr. med. Véronique Grobéty[ ]  Prof. Dr. med. Michael Seitz[ ]  Dr. med. Isabel Bolt[ ]  offen |
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| **Anamnese, Verdachtsdiagnose, Fragestellung** |
| ....................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................... |
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| **Aktuelle Medikation**  |
| .................................................................................................................................................................................................................................................................................................................................. |
|  |
| **Bemerkungen** |
| ....................................................................................................................................... |
|  |
| Datum:       | Unterschrift/Stempel:       |