Praxis für Viszeral-Chirurgie PD Dr. med. D. Bimmler

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Referral Form

Reason for referral/reason for consultation (Initial consultation, second opinion, surgery discussion, follow-up, etc.)

Name ______ First name ______ Date of birth ______ Phone number ______

Street, Number ______ ZIP Code ______ Location ______ E-mail ______

Health insurance ______

Insurance status
- ☐ whole Switzerland
- ☐ Canton of residence
- ☐ Flex
- ☐ Semi private
- ☐ Private

Family doctor model
- ☐ Yes
- ☐ No

How should we handle you?
- ☐ Phone
- ☐ SMS
- ☐ E-mail

Priority?
- ☐ Emergency (same day)
- ☐ urgent (within 2-3 days)
- ☐ elective (within 2-3 weeks)

General practitioner ______ Other attending physician ______

Main complaints

______

Other diagnoses / surgeries (please attach surgery reports if available)

______

High blood pressure	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Heart diseases	☐ Yes	☐ No	If so, which?
Pulmonary diseases	☐ Yes	☐ No	If so, which?
Kidney diseases	☐ Yes	☐ No	If so, which?

Existing diagnostics (X-ray, CT, MRI, endoscopies, etc. [please attach reports if available])

______

Medication

______

Allergies	☐ Yes	☐ No	If so, which?
Blood Thinner	☐ Yes	☐ No	
Nicotine	☐ Yes	☐ No	

Comments/Request additional reports (e.g., physician's reports) (If yes, where?)

______

Referring physician (name, address, e-mail)

______

______

______

Date

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