|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name |  |  | Vorname |  |
| Geburtsdatum |  |  | Tel.-Nummer |  |
| Adresse |  |  | Mobile-Nr. |  |
| PLZ |  |  | Ort |  |
| Krankenkasse |  |  |  |  |
|  |  |  |  |  |

**Gewünschte Untersuchung**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Gastroskopie |  |  | Abdomensonographie |
|  | Koloskopie |  |  | Leberbiopsie |
|  | Rektosigmoidoskopie |  |  | H2 – Atemtest |
|  | Proktoskopie |  |  | Gastroenterologisches Konsilium |
|  | starre Endosonographie |  |  | Hepatologisches Konsilium |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | OAK |  | Aspirin |  | Clopidogrel |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| INR/ Quick |  |  | Thrombozyten |  | vom |  |

**Jetziges Leiden / Klinischer Befund**

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|  |

**Fragestellung**

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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Termin bereits vereinbart am |  |  |  | Bitte aufbieten |

**Bericht bitte per**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Telefon |  | Fax |  | E-Mail |  | Post |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Datum |  |  | Arzt / Ärztin (Stempel) |  |