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

**Gewünschte Untersuchung**

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| --- | --- | --- | --- | --- |
| [ ]  | Gastroskopie |  | [ ]  | Leberbiopsie |
| [ ]  | Koloskopie |  | [ ]  | H2 – Atemtest |
| [ ]  | Rektosigmoidoskopie |  | [ ]  | Gastroenterologisches Konsilium |
| [ ]  | Proktoskopie |  | [ ]  | Hepatologisches Konsilium |
| [ ]  | Abdomensonographie |  |  |  |

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| --- | --- | --- | --- | --- | --- |
| [ ]  | OAK | [ ]  | Aspirin | [ ]  | Clopidogrel |

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| --- | --- | --- | --- | --- | --- | --- |
| 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) |       |