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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Anmeldung Röntgen und Sonographie**  **Reha Rheinfelden**  **Röntgen**  Salinenstrasse 98  CH-4310 Rheinfelden  Telefon +41 (0)61 836 52 60  Fax +41 (0)61 836 52 69  E-Mail [roentgen@reha-rhf.ch](mailto:roentgen@reha-rhf.ch)  [www.reha-rheinfelden.ch](http://www.reha-rheinfelden.ch) | | | | | | | | | | |  | | | | |
|  | | | | | | | | | | | | | | | |
| **Wir melden folgende Patientin / folgenden Patienten an:** | | | | | | | | | | | | | | | |
| Name | | | w m | | | | | | | | Geburtsdatum | | | |  |
| Vorname | | |  | | | | | | | | Telefon-Nr. | | | |  |
| Adresse | | |  | | | | | | | | Versicherer | | | |  |
| PLZ, Ort | | |  | | | | | | | | Vers.- / Unfall-Nr. | | | |  |
| Krankenkasse: | | | | | | Sektion: | | | | | | | Ausweis Nr.: | | |
| Unfallversicherung, Unfall-Nummer: | | | | | | Arbeitgeber: | | | | | | | | | |
|  | | | | | |  | | | | | | | | | |
| **BITTE KRANKENKASSENAUSWEIS UND VORAUFNAHMEN MITBRINGEN!** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Gewünschte Untersuchung** | | | | | | | | | | | | | | | |
|  | **Röntgendiagnostik** | | | | | | | | | | | | | | |
|  | Region: | | | | | | | | | | | | | | |
|  | **Sonographie** | | | | | | | | | | | | | | |
|  | Region: | | | | | | | | | | | | | | |
| **Anamnese, klinische Angaben und Fragestellungen** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Notwendige Aufgaben** | | | | | | | | | | | | | | | |
| Schwangerschaft | | | | |  | | Nein | |  | Ja | | Datum letzte Menstruation: | | | |
| Implantate, Fremdkörper: | | | | |  | | Nein | |  | Ja | | Was? | | | |
|  | Untersuchungstermin | | | | Datum: | | |  | | | | Zeit: | |  | |
|  | Kontrolltermin beim Zuweiser | | | | Datum: | | |  | | | | Zeit: | |  | |
|  | | | | | | | | | | | | | | | |
|  | Patient bitte aufbieten | | | | | | | | **Berichterstattung** | | | | | | |
|  | Patient meldet sich selbst an | | | | | | | |  | Per Telefon: | | | |  | |
|  | |  | | | | | | |  | Per Fax: | | | |  | |
|  | |  | | | | | | |  | Per E-Mail: | | | |  | |
|  | |  | | | | | | |  | Berichtskopie an: | | | |  | |
|  | | | | | | | | | | | | | | | |
| Datum: | | | | **Zuweiser**:  ZSR-Nr.  PLZ / Ort  Telefon / Fax  E-Mail  Unterschrift / Stempel | | | | |  | | | | | | |