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| **Einweisender Arzt / Einweisendes Spital** | | | | | | | | | | |
| Institution | | | | | | | | | | |
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| Adresse | |  |  | PLZ, Ort | | | |  | | |
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| **PatientIn** | | |  |  | | | |  | | |
| Name | |  |  | Vorname | | | |  | | |
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| Geburtsdatum | |  |  | Geschlecht | | | | |  | |
|  | | |  | Weiblich Männlich andere | | | | | | |
| Adresse | |  |  | PLZ, Ort | | | |  | | |
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| **Versicherung** | | | | | | | | | | |
| Grundversicherung | |  |  | Versicherungsklasse | | | | | | |
|  | | |  | Allgemein | | halbprivat | Privat | | | Selbstzahler |
| AHV-Nr. | |  |  | Zusatzversicherung | | |  | | | |
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| **Einweisungsgrund** | | | | | | | | | | |
| Innert 24h Wunschtermin: | | |  |  | | | |  | | |
|  | |  |  |  | | | |  | | |
| **Diagnosen / aktuelle Beschwerden / aktuelle Medikation / Ziel der Behandlung:** | | | | | | | | | | |
| Text Erweiterungsfeld | | | | | | | | | | |
| **Anhänge hochladen** | **(1-5 je max. 3 MB - PDF/JPG)** | | | |