Registration Form

RIMED
Mühlebachstrasse 7
8008 Zürich
1. Floor

Send via E-Mail to: bellevue@rimed.ch / metarad@hin.ch
Phone: +41 43 222 60 70 / Fax: +41 43 222 60 80

Personal Information		
Last Name: ______________________________	First Name: ____________________________	
Date of Birth: _____________________________	Male	Female
Address, ZIP, City: ____		
Phone Number: ____		

Cost Bearer		
Health Insurance: ______________________	Member No.: ___________________________	
SUVA/IV: ______________________________	Claim No.: _____________________________	
Please schedule	Emergency Case	
Already scheduled	Date: ______________	Time: ______________

Gewünschte Untersuchung				
MRI	CT	X-Ray	Ultrasound	PRT
Arthrography		FNP	Intervention	

Clinical Information

Clinical Question		
Pregnancy	Yes	No

For MRI Examinations	For CT Examinations		For Arthrograph	
Claustrophobia	Hyperthyreodism		Anticoagulant Therapy	
Allergies - specify: ______	Yes	No	Yes	No
Neurostimulator	Current Medication: ______		Which Anticoagulants: ______	
Brain or Cardiac Surgery	Diabetes		**For Interventions / FNP**	
If yes, specify: ______	Renal Insufficiency		Platelet count:	
	If yes, eGFR: ______		Quick:	
Year of procedure: ______			INR:	
			Date:	
Presence of implants: ______				

Date: ______		If available, please attach the surgical report	
Reporting preference via Mail	Additional copy via:	Post: ______	Phone call ______
Referring Physician / Stamp / Signature			
		Date: ______	
		Phone Number: ______	
		Secured Mail (HIN): ______	