*Treatments are exclusively on medical prescription !!! | * = required*

Assignment Form

Refering Doctor

Punch Refering Doctor

☐ **Urgent**

Date*: _____

Schänzlistrasse 45
3013 Berne
Suisse
Phone +41 (0) 31 330 60 70
Fax +41 (0) 31 330 60 74
neurozentrum@nzbern.ch
www.nzbern.ch

Patient

First Name*: _____
Last Name*: _____
Street/No.*: _____
ZIP/City*: _____
Health insurance: _____
Insurance No.: _____

Gender*: ○ male ○ female
Date of Birth*: _____
Phone privat*: _____
Phone business: _____
Mobile: _____
E-mail: _____
Medication*: _____

Appendices/reports/imagery:

○ in the appendix
○ with separate mail
○ by separate e-mail
○ by fax
○ are brought by the patient

Assignment to*

○ Assignment to all
○ Dr Isabel Charlotte Keller
○ Dr Kai Liesirova
○ Dr Sebastian Humpert
○ Dr Tobias Haefeli
○ Dr Verena Blatter
○ Dr Anne Mugglin
○ Prof. Dr Johannes Mathis
○ Prof. Dr Bernhard Voller

Neuropsychology

○ Dr Silvia Chaves
○ Dr Dörthe Heinemann

Reason(s) for assignment*

☐ Other (see remarks)
☐ Dementia
☐ Epilepsy
☐ Cerebral function disorder
☐ Carpal tunnel syndrome ○ both ○ R ○ L
☐ M. Parkinson's disease
☐ Multiple sclerosis
☐ Polyneuropathy
☐ Restless legs syndrome
☐ Back pain
☐ Head trauma/whiplash
☐ Vertigo examination
☐ Syncope examination
☐ TIA examination
☐ Ulnar compression ○ both ○ R ○ L

Remarks

send | print | save | reset

Thanks for your cooperation!