Referral form

Receiving doctor: Schwanenpraxis Luzern,
Dr. Kalgini Durrer-Ariyakuddi, Schwanenplatz 7, 6004 Luzern,
schwanenpraxis@hin.ch, Tel.: 041 410 73 71

Referring doctor:

Practice name

Phone number*

Address*

First name*

Last name*

Email*

ZRS/GLT number

Patient details:

First name*

Last name*

Address*

Phone Number*

Email

SHI name

SHI number

Reason for referral*

- ○ Not selected
- ○ Afib screening
- ○ Syncope
- ○ Other
- ○ Palpitations
- ○ Dizziness
- ○ Optimizing treatment

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Remarks

Requested examination*

- ○ Langzeit EKG 1 Tage
- ○ Langzeit EKG 2 Tage
- ○ Langzeit EKG 3 Tage
- ○ Langzeit EKG 4 Tage
- ○ Langzeit EKG 5 Tage
- ○ Langzeit EKG 6 Tage
- ○ Langzeit EKG 7 Tage

Additional patient information:

Patients history (relev. to requested examination) *	○ none	○ attached as pdf	○ sent by email
Actual medication (relev. to requested examination)*	○ none	○ attached as pdf	○ sent by email
Additional informations (relev. to requ. examination)*	○ none	○ attached as pdf	○ sent by email

With this referral, the referring doctor confirms, that the patient has been informed and has either personally or by his legal representation signed the two consent declarations: ○ *data transfer consent** ○ *invoicing consent**
Both forms remain with the doctor, but shall be provided to the receiving doctor anytime on request!

Date of referral:*