**Richiesta di esame radiologico**

Centro di Radiologia e Senologia Luganese

Via Pretorio 9 [www.radiologia-senologia.ch](http://www.radiologia-senologia.ch)

6900 Lugano info@radiologia-senologia.ch

T.+4191 922 77 00 F. +4191 922 77 06

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|  **Dati paziente** |  |
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| Nome |

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| Cognome |

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| Data di nascita |

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| Tel. |

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| Indirizzo |

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| Mobile |

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 |  Genere 🞎 M 🞎 F  |

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|  **Appuntamento** |  |  |
|  🞎 Da convocare |  🞎 Già fissato per il | 🞎 Urgente, entro il  |

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|  **Indagine radiologica chiesta** indicare parte del corpo |  |
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|  🞎 MRI |

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|  🞎 Eco Doppler |

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|  🞎 Ecografia |

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|  🞎 TAC + valore creatinina = |

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|  🞎 Mammografia |

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|  🞎 RX Conv  |

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|  🞎 Altri esami |

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|  **Quesito clinico** | **Dati clinici**

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| Gravidanza |  |  🞎 si  |  🞎 no |
| Portatore di pacemaker |  |  🞎 si  |  🞎 no |
| Diabete |  |  🞎 si  |  🞎 no |
| Assunzione di Metformina |  |  🞎 si  |  🞎 no |
| Conosciuta ipertireosi |  |  🞎 si  |  🞎 no |
| Insufficienza renale |  |  🞎 si  |  🞎 no |
| Valore creatinina |  |  |  |
| Allergie |  |  🞎 si  |  🞎 no |
| Quali? |  |  |  |
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|  **Esami precedenti**

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|  🞎 si  | PF allegare esami radiologici precedenti |
| nome istituto |  |  |
| data |  |  |

 | **Consegna referto**

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|  🞎 e-mail  |  🞎 fax |  🞎 posta |
|  |  | specificare |
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|  🞎 no  |  |

 | **Consegna CD**

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|  🞎 al paziente  |  🞎 al medico |

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|  | **Medico inviante** data timbro e firma |