**Richiesta di esame radiologico**

Centro di Radiologia e Senologia Luganese

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| **Dati paziente** |  |
| |  | | --- | | Nome | | |  | | --- | | Cognome | |
| |  | | --- | | Data di nascita | | |  | | --- | | Tel. | |
| |  | | --- | | Indirizzo | | |  | | --- | | Mobile | |
| |  | | --- | |  | | 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 |  |
| |  | | --- | | 🞎 MRI | | |  | | --- | | 🞎 Eco Doppler | |
| |  | | --- | | 🞎 Ecografia | | |  | | --- | | 🞎 TAC + valore creatinina = | |
| |  | | --- | | 🞎 Mammografia | | |  | | --- | |  | |
| |  | | --- | | 🞎 RX Conv | | |  | | --- | | 🞎 Altri esami | |

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| **Quesito clinico** | **Dati clinici**   |  |  |  |  | | --- | --- | --- | --- | | 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? |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |
| **Esami precedenti**   |  |  |  | | --- | --- | --- | | 🞎 si | PF allegare esami radiologici precedenti | | | nome istituto |  |  | | data |  |  | | **Consegna referto**   |  |  |  | | --- | --- | --- | | 🞎 e-mail | 🞎 fax | 🞎 posta | |  |  | specificare | |  |  |  | |
| |  |  | | --- | --- | | 🞎 no |  | | **Consegna CD**   |  |  | | --- | --- | | 🞎 al paziente | 🞎 al medico | |

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