Gynaikon Klinieken

Referral

To be completed by your GP/referrer

Referral to: Gynaikon Kliniek Rotterdam
Gynaikon Kliniek Roermond

PATIENT DETAILS:

Surname:

First name:

Date of birth:

Address:

Postcode + town/city:

Date of 1st consultation:

Blood group / Rh.:

Grav.:

Para.:

SC:

First day of last menstrual period:

Gestational age (weeks of amenorrhoea):

Pregnancy confirmed through:
Urine test
hysical exam
Blood test
Ultrasound scan

Medication use:

GYNAIKON KLINIEKEN
Strevelsweg 700 - 204, NL-3083 AS Rotterdam
Bredeweg 239 - S1, NL-6043 GA Roermond
tel. +31 (0)88 8884444
info@gynaikon.nl
AGB-code 49-493202
www.gynaikonklinieken.nl

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Allergies:

Medical history:

Blood transfusion	Abdominal surgery	Anaemia
Coagulation disorders	Heart diseases	Gynaecol. surgery
Sexually transm. dis.	Hypertension	Kidney diseases
Mental illnesses	Diabetes	Pulmonary diseases
Infectious diseases	Neurol. dis.	Epilepsy

Other, please specify:

Indication:

REFERRER DETAILS:

Name:

Organisation:

Address:

Postcode + town/city:

Telephone number:

Email:

How to send:

Save this file as 'ReferralLetter_Date_PatientSurname' and send it as an attachment or through the Zivver Secure Email app to:

info@gynaikon.nl