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, 3083 AS Rotterdam
Bredeweg 239 - S1, 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
- ☐ Coagulation disorders
- ☐ Sexually transm. dis.
- ☐ Mental illnesses
- ☐ Infectious diseases
- ☐ Abdominal surgery
- ☐ Heart diseases
- ☐ Hypertension
- ☐ Diabetes
- ☐ Neurol. dis.
- ☐ Anaemia
- ☐ Gynaecol. surgery
- ☐ Kidney diseases
- ☐ Pulmonary diseases
- ☐ 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

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BIRTH CONTROL, ABORTION, AND MENOPAUSE SPECIALIST