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| CT tel.: 043/4203521 | | | | | | | | | | | | | | | | | | | |
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| **Žiadanka na CT vyšetrenie** | | | | | | | | | | | | | | | | | | | |
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| Vypísať dvojmo a všetky kolónky! | | | | | | | | | | | | | | | | | | | |
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| Priezvisko: |  | | | | | | | | | | | | | | | | | | |
| Meno: |  | | | | | | | | | Rodné číslo: | | | | |  | | | | |
| Bydlisko: |  | | | | | | | | | Kód poisťovne: | | | | |  | | | | |
| Výška: cm, hmotnosť: kg ID prípad:    Odosielajúci lekár (meno, adresa, oddelenie):  Tel./klapka: | | | | | | | | | | | | | | | | | | | |
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| Kód odosielajúceho lekára: | | |  |  |  |  | |  | | |  |  |  |  | |  |  |  |  |
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| Kód oddelenia: | | |  |  |  |  | |  | | |  |  |  |  | |  |  |  |  |
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| Predchádzajúce vyšetrenie (CT a MR). Kde? Kedy? | | | | | | |  | | | | | | | | | | | | |
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| Pacient objednaný na deň: | | | | | | | | | Hod: | | | | | | | | | | |
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| Termín vyšetrenia oznámiť na adresu lekára / pacienta (tel.): | | | | | | | | | | | | | | | | | | | |
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| Ktorý orgán má byť vyšetrený? | |  | | | | | | | | | | | | | | | | | |
| Glomerulárna filtrácia (eGF):  Alergia v anamnéze: | |  | | | | | | | | | | | | | | | | | |
| Otázka, ktorá má byť vyšetrením zodpovedaná (dif. dg možnosti): | | | | | | | | | | | | | | | | | | | |
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| Klinická diagnóza (slovom): | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | Štatistický kód: | | | | | |  | | | | |
| Epikríza s výsledkami doterajších vyšetrení: | | | | | | | | | | | | | | | | | | | |
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| Metformín, thyreotoxikóza, hypertyreóza, liečba rádiojódom: | | | | | | | | | | | | | | | | | | | |
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| Priložte popisy + CD všetkých vyšetrení, ktoré súvisia s diagnózou. | | | | | | | | | | | | | | | | | | | |
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| Dátum: | | | | | | | Pečiatka a podpis ošetrujúceho lekára | | | | | | | | | | | | |