KPT, PO Box, CH-3001 Bern
kpt.ch

Referral confirmation

First name _____

Last name _____

Street _____

Postcode/town _____

Date of birth _____

Policy no. _____

For completion by the general practitioner:

☐ The patient was referred by me.

☐ The patient was referred by a specialist. I have been informed about the referral and agree to its pertinence for the treatment.

Date of the consultation that led to the referral: _____

Referral to _____

Referral valid from _____

Hospital doctor ☐ Yes ☐ No

Hospital _____

Referral period _____

☐ The patient was not referred by me.

☐ Not my patient.

Comments _____

_____

_____

Place/date _____

Stamp and signature of doctor _____

Please complete the form and send the signed version to:

KPT, PO Box, 3001 Bern or fax +41 (0)58 310 86 35. Thank you.