



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

Referral confirmation KPTwin.doc

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.

