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| Pieczątka jednostki kierującej | **Skierowanie do Zakładu Radiologii i Medycyny Nuklearnej** |
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| ***HGH (0´)*** | | | | | | | | | | | | | | | | | | | | | |  | ***HGH (60´)*** | | |  | ***HGH (120´)*** | | |  |  | | | | | | | | | | | | | | |
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| Pani (Pan): ………………………………………………………………………………………..……………….….… | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Płeć: | | | K | |  | M | | |  | |
| Adres: ………………………………………………………………………………………………………...………… | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Telefon: …….…………...…. | | | | | | | | | | |
| PESEL\*: |  |  |  |  |  | |  | |  | | |  | | |  | |  | |  | | ……………………...…………….……………........……… | | | | | | | | | | | | | | Data ur: ………….…....….… | | | | | | | | | | |
| Rozpoznanie: ………………………………………………………………………….…………………………………………………………….……... | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| W przypadku, gdy badanie wykonujemy w trybie ambulatoryjnym i pacjentem jest osoba małoletnia, całkowicie ubezwłasnowolniona  lub niezdolna do świadomego wyrażania zgody, należy wpisać: **imię i nazwisko oraz adres zamieszkania przedstawiciela ustawowego**. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Krótki wywiad: …………………..……………………………………………………………….…………….……………………..……….…...……... | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Leczenie: …………………………...………………………………………..…………………………...………………..……………………….……… | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Data pobrania materiału: | | | | | |  | |  | | **-** | | |  | | |  | | **-** | |  | |  |  |  | Godzina pobrania: | | |  |  | **:** |  |  |  | ………………………………….. | | | | | | | | | | | |
| (dzień) (miesiąc) (rok) Czytelny podpis osoby pobierającej | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Data przyjęcia materiału: | | | | | |  | |  | | **-** | | |  | | |  | | **-** | |  | |  |  |  | Godzina przyjęcia: | | |  |  | **:** |  |  |  | | | | | | | | | | | | |
| (dzień) (miesiąc) (rok) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \* w przypadku osób, które nie mają nadanego numeru PESEL, należy podać rodzaj i numer dokumentu potwierdzającego tożsamość,  a w przypadku noworodka należy podać numer PESEL matki.    Lublin, dnia ........................... Pieczątka i podpis lekarza kierującego …………….…………………..………....…………….…. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| |  |  | | --- | --- | | Pieczątka jednostki kierującej | **Skierowanie do Zakładu Radiologii i Medycyny Nuklearnej** | | **USK nr 4 w Lublinie, ul. Dra K. Jaczewskiego 8c, rejestracja tel.: 81 724-43-87, 81 724-41-21** | | Program zewnętrznej kontroli jakości badań we współpracy z firmą Randox Laboratories ltd. | | SKIEROWANIE NA BADANIE RADIOIMMUNOLOGICZNE |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ***Poziom:*** | | | | | | ***FT3*** | | | | |  | | | ***FT4*** | | | | | | | |  | ***TSH*** | | |  | ***TR – Ab*** | | |  | ***anty – TPO*** | | | | |  | **anty TG** | | | | |  | | |  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ***HGH (0´)*** | | | | | | | | | | | | | | | | | | | | | |  | ***HGH (60´)*** | | |  | ***HGH (120´)*** | | |  |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Pani (Pan): ………………………………………………………………………………………..……………….….… | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Płeć: | | | K | |  | M | | |  | | | Adres: ………………………………………………………………………………………………………...………… | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Telefon: …….…………...…. | | | | | | | | | | | | PESEL\*: |  |  |  |  |  | |  | |  | | |  | | |  | |  | |  | | ……………………...…………….……………........……… | | | | | | | | | | | | | | Data ur: ………….…....….… | | | | | | | | | | | | Rozpoznanie: ………………………………………………………………………….…………………………………………………………….……... | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ……………………………………………………………………………………………………………………… | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Kod ICD-10: | | | | |  |  |  | | **.** |  | | | ……………………………………………………………………………………………………………………………………………………………… | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | W przypadku, gdy badanie wykonujemy w trybie ambulatoryjnym i pacjentem jest osoba małoletnia, całkowicie ubezwłasnowolniona  lub niezdolna do świadomego wyrażania zgody, należy wpisać: **imię i nazwisko oraz adres zamieszkania przedstawiciela ustawowego**. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Krótki wywiad: …………………..……………………………………………………………….…………….……………………..……….…...……... | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ……………………………………………………………………………………………………………………………………………………………… | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Leczenie: …………………………...………………………………………..…………………………...………………..……………………….……… | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ……………………………………………………………………………………………………………………………………………………………… | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Data pobrania materiału: | | | | | |  | |  | | **-** | | |  | | |  | | **-** | |  | |  |  |  | Godzina pobrania: | | |  |  | **:** |  |  |  | ………………………………….. | | | | | | | | | | | | | (dzień) (miesiąc) (rok) Czytelny podpis osoby pobierającej | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Data przyjęcia materiału: | | | | | |  | |  | | **-** | | |  | | |  | | **-** | |  | |  |  |  | Godzina przyjęcia: | | |  |  | **:** |  |  |  | | | | | | | | | | | | | | (dzień) (miesiąc) (rok) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | \* w przypadku osób, które nie mają nadanego numeru PESEL, należy podać rodzaj i numer dokumentu potwierdzającego tożsamość,  a w przypadku noworodka należy podać numer PESEL matki.    Lublin, dnia ........................... Pieczątka i podpis lekarza kierującego …………….…………………..………....…………….…. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |