

Patient family name: **First name:**

Date of birth: female male

Phone: private business Cellphone

E-mail address:

Postal address:

Health insurance: self-payer private insurance (which one): other

Diagnosis: Scoliosis Spinal injury Spinal tumor Disc damage
 Kyphosis Discopathy Spondylolisthesis

Localization of pain:

Cervical spine Thoracic spine Lumbar spine Arms Legs

Are there symptoms of paresis? Arm(s) Leg(s)

Please describe your symptoms (keywords only):
.....
.....

Do you have current examination reports (max 3 months old)?

Orthopaedist Neurologist Neurosurgeon

Which diagnostic measures have been carried out? Please state date and examined body region

Conventional X-ray: CT scan:
 MRI: Myelography:

Which operations were carried out? State name of hospital

- Intervertebral disc surgery
- Spinal fusion surgery
- Corrective surgery
- Others:

Is there currently a medical necessity for surgery? Yes No I am not sure

Do you wish to consult a particular doctor?

- Yes, Professor Dr. Harms
- Yes, Associate Professor Dr. Orakcioglu

.....
Date

Signature

Please send the completed form, together with the original CD of your current radiographs (MRI, X-ray, etc.) and relevant medical reports, to

ETHIANUM Heidelberg
Helga Reblin
Vossstrasse 6
69115 Heidelberg
Germany

After reviewing and assessment of the documents, we will get in touch with you.
Many thanks and best regards,

Helga Reblin