Dr. Vanni VERONESI
Website: www.vanniveronesi.com
YouTube Channel: https://www.youtube.com/@veronesisectionfilumterminale

SECOND OPINION
MODULE 2: REQUEST FOR A SECOND OPINION

REQUEST FOR A SECOND OPINION FROM VERONESI MD

PATIENT INFORMATION

Surname ______________________ First Name ______________________

Date and place of birth ____

Gender: □ Male. □ Female

Residential Address ____

City ______________________________ Country ____________________

Citizenship ____

Telephone ______________________ Fax __________________________

Mobile ______________________ Email_____________@____________

APPLICANT INFORMATION (to be completed only if the applicant is not the patient)

Surname ______________________ First Name______________________

Date and place of birth ____

Gender: □ Male □ Female

Citizenship ____

Residential Address ____

City ______________________________Province ____ Zip Code _________

Telephone ______________________ Fax ________________________

Mobile __________________ Email_______________@___________

Patient Relationship (check one of the options below)

- Parent of a minor with custody (with family status)
-
- Person exercising guardianship, curatorship, or support administration (with supporting documentation)

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Please indicate the format in which you would like to receive Veronesi's Second Opinion report:

□ Email □ Fax

Please indicate the language in which you would like it to be delivered.
Receive Veronesi's Second Opinion report (please select only one language):

□ Italian □ English

DIAGNOSIS and CLINICAL QUESTION(S)

What is the current diagnosis? Please be brief, clear, and concise.

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Please note that the requested consultation is neurosurgical.
Any questions you may have for neurosurgeon Veronesi

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CLINICAL DOCUMENTATION REQUIRED:
Documents and materials submitted will be archived by Veronesi.
All clinical documentation must be in Italian or English.

- Diagnostic test reports (CT, MRI, X-ray).

- Specialists visit reports.

- Discharge letters from any hospital admissions.

- An accompanying report from your referring physician that must contain the following information: diagnosis, medical history, allergies, current therapies, medications taken at home, active problems, and the clinical question for the Second Opinion.

Date _________________________

Patient or Legal Representative Signature

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