

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.

Please note that the requested consultation is neurosurgical.

Any questions you may have for neurosurgeon Veronesi

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
