Confirmation of referral

Insured person

First name		Surname	
Street, no.		Postcode, town/city	
Visana insurance no.		Date of birth	

(Please tick where applicable)

◯ was referred by me

Date of referral	
Referral to	
Duration of referral	

◯ was **not** referred by me

◯ I have been informed about the treatment and agree to the cost coverage

◯ is not my patient

Remarks			
Place, date		Doctor's stamp/ signature	

V-1028 - 08.2026