STANDARD ANSWER FORM VTB

- ***REQUEST NUMBER*** *(attach request form)**:***

- **PHYSICIAN NAME:**
- **INSTITUTION:**
- **COUNTRY:**
- **PATIENT'S NAME:**
- **DATE OF BIRTH:**
- **DATE OF DIAGNOSIS:**
- **CONCRETE REASON OF CONSULTATION:**

- **DATE OF VTB:**
- **VTB MEMBERS:**

- **ACTION POINTS:**

- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

- **COMMENTS:**

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