

GENERAL PATIENT INFORMATION

First / Given name: _____

Last / Family name: _____

Address: _____

City: _____

Country: _____

Postal / ZIP code: _____

Telephone (home): _____

Telephone (work): _____

Fax: _____

E-Mail: _____

Religion: _____

Date of birth (month/day/year): _____

REFERRING PHYSICIAN INFORMATION

First / Given name: _____

Last / Family name: _____

Address: _____

City: _____

Country: _____

Postal / ZIP code: _____

Specialty: _____

Telephone: _____

Fax: _____

E-Mail: _____

If other than patient or physician, person completing this form:

First / Given Name: _____ Last / Family Name: _____

Relation to Patient: _____

REASON FOR CONSULTATION

- Emergency
- Confirm a diagnosis/Second Opinion
- Seek a diagnosis
- Seek treatment
- Other: _____

Does the patient require critical care transport?

Yes No

Will an interpreter be needed to accompany the Patient during this medical visit?

Yes No

PATIENT MEDICAL INFORMATION

Chief complaint / Current diagnosis: _____

Past medical history (include any relevant information such as history of diabetes, heart disease, past surgeries, alcohol use, tobacco use, etc.): _____

Previous examination(s) performed (include dates):

- X-Rays (specify) _____
- Ultrasound (specify) _____
- Magnetic Resonance Imaging (MRI) (specify) _____
- Other (specify) _____

Drug or food allergies: _____

Weight (kg): _____ Height (cm): _____

Current Medication: _____

List hospitals where patient was previously hospitalized (if any) and reason of hospitalization: _____

Tentative date of visit at the Hospital: _____

Method of payment (self-pay, international insurance, government or embassy-sponsored): _____

ADDITIONAL INFORMATION

Person who will accompany patient to the Hospital:

First / Given Name: _____

Last / Family Name: _____

Telephone: _____

Relation to Patient: _____