

HCA International Patient Centre Referral Form

Please email or fax to HCA International Business on +44(0)20 7759 3825

1. ABOUT THE PATIENT

Title	First Name	Family / Last Name			
		Male <input type="checkbox"/> : Female <input type="checkbox"/>	Nationality		
Previously treated at a HCA Hospital? Yes <input type="checkbox"/> : No <input type="checkbox"/> If Yes, MR number if known: X					
Date of Birth		Email address			
Home Address			London Address		
			In London from:		
Contact details of the patient:					
Work phone		Home phone			
Mobile phone		Fax number			
Other Unique Identifier					
Passport Number					
National Identity Card No:					

2. ABOUT THE REFERRAL SOURCE (IF APPLICABLE)

Referring Doctor:	
Referrers Contact Details	
Address	
Phone	
Fax	
Email	

3. ABOUT THE TREATMENT SOUGHT

Reason for referral: 2 nd Opinion <input type="checkbox"/> : Appointment with Doctor <input type="checkbox"/> : Admission to hospital <input type="checkbox"/> : Other – specify <input type="checkbox"/>	
Main complaint / diagnosis / speciality sought	Medical report provided <input type="checkbox"/> Number of Pages: Medical Report to follow <input type="checkbox"/> X-rays provided <input type="checkbox"/> X-rays to follow <input type="checkbox"/>

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4. INFORMATION PROVIDED BY

Accompanied?

Unaccompanied : Yes by mother : Yes by father : Yes by child : Yes by other :

If Yes: Name of Companion:

Special requests: Interpreter if Yes – Language:

Access assistance Yes : Advice on hotel accommodation in London : Flight advice wanted :

Visa to be arranged Yes by HCA : Yes by self Not applicable : Other please specify

I understand that the purpose of recording and transmitting this information is:

- to support the referral request for treatment at a HCA facility,
- if the application is approved, to provide those healthcare services including arranging appointment travel, visas and accommodation and
- to release medical record information about the patient for the purposes of facilitating treatment.

I understand that I may withdraw consent at any time by contacting International Patient Centre.

Signature of patient / guardian:

Date: