UHN Medical Solutions
A DIVISION OF ALTUM HEALTH

INTERNATIONAL PATIENT APPLICATION

Dear International Patient:

In order for a patient to be considered for treatment / management at University Health Network, please email all completed forms to the **International Patient Program** at ipp@uhn.ca or fax to **416-603-5406, Attention: International Patient Program.**

****Before sending in your application, please check to ensure all of these documents are included****

□ Completed IPP Application form with signature from physician and patient (email consents)
□ A Physician Referral letter, signed by your home country doctor, stating why treatment is sought at UHN.
□ Current medical records, in **English**, including lab reports, diagnostic reports/discs/film, and notes from the referring physician and home country hospitals.

I. To be completed by the PATIENT or DESIGNATE

Patient Information	
Patient Last Name:	**Permanent Address:**
Patient First Name:	
Gender: **[ ] Male [ ] Female**	**Home Telephone #:**
Date of Birth (DD/MM/YYYY):	**Mobile #:**
E-mail Address:	

RESIDENCY & CITIZENSHIP(S)		
Please list all countries where you have citizenship or residency:	**Canadian Resident:**	**[ ] Yes [ ] No**
	Canadian Citizen:	**[ ] Yes [ ] No**
	Is the patient currently in Canada?	**[ ] Yes [ ] No**
	If so, for how long?	

PAYMENT & INSURANCE	
Please indicate how you intend to pay for care at UHN and provide all relevant contact information. All services provided must be paid for in advance of services rendered.	
[ ]	**Insurance** **Name:** **Policy Number:** **Contact Information (telephone/e-mail):**
[ ]	**Paid by country of origin**

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	Country/Embassy:
[ ]	**Paid by patient him/herself**
[ ]	**Other (specify):**

Information & Authorization for Communication with Representative(s)	
Authorized Representatives and E-mail Consent. *Please indicate case managers from insurance companies as well as any family members.* *Please list representatives that you authorize UHN to discuss details of your case and provide updates regarding acceptance to UHN's IPP.*	**Name:** **Relationship:** **E-mail:**
	Name: **Relationship:** **E-mail:**
Please list any representative(s) in Canada that will be providing support or accommodation. *Contact Information (if different from patient's):*	**Name:** **Relationship:** **E-mail:** **Address:** **Phone:**

LANGUAGE	
If interpretation is required, UHN policy mandates that an independent interpreter (i.e. not a family member or friend) be present for all medical appointments to ensure informed consent and decision-making. An interpreter will be scheduled by the International Patient Program, and the cost will be built into the estimate provided in advance for the required services.	
Does the patient speak & understand English sufficiently to make informed decisions? **[ ] Yes [ ] No**	**If no, list language for interpreter services:**

Confirmation of Information Provided & Email Communication Consent

I agree to the use of email communication regarding information pertaining to my care at UHN between myself, the authorized representatives listed above or any other designated third party. I also agree that the above information provided is lawfully correct. **

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Patient Signature: ______________________________ **Date:** ________________________

Witness Signature:______________________________ **Date:** ________________________

II. To be completed by the referring home country PHYSICIAN

PHYSICIAN CONTACT INFORMATION	
Physician Name:	**E-mail:** **Phone Number:**
Address:	**Fax:** **Telemedicine Conferencing:** [ ] Yes [ ] No **Preferred method of communication:** [ ] E-mail [ ] Phone

Patient Information	
Patient Last Name:	**Date of Birth (DD/MM/YYYY):**
Patient First Name:	**Gender:** [ ] Male [ ] Female

Patient Medical History
Diagnosis: **Diagnosis date (Month/Year):**
Please identify why this patient is being referred to UHN:

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[ ] **Care is not available in home country.** [ ] **Care is available; however, because of exceptional circumstances the patient requires treatment at UHN.** **If yes, please describe:** ______________________________ [ ] **The patient is being self-referred upon their own will.**
Treatment to Date:
Recommended Treatment:

Current Medications & Dosages:
Additional Comments:

<u>Please send all supporting documents, test results, or investigations with this referral form and include what is available from the time of diagnosis to present date.</u>

Referrals will be triaged and scheduled based on a standard priority scale. Incomplete referrals will delay the booking process. The patient's referring doctor will be notified by phone regarding their patient's appointment date and time.

<u>Signature of Physician and Office Stamp</u>

<u>Referring Physician Signature:</u>

We have determined that this patient fits the appropriate criteria (as indicated above) and, therefore, I have referred this patient for investigation and treatment at UHN.

Signature:____

OFFICE STAMP OF REFERRING PHYSICIAN