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 by placing an 'X' next to the payment method. 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** **Country/Embassy:**
[ ]	**Paid by patient him/herself**
[ ]	**Other (specify):**

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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 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:**

CONCIERGE SERVICES	
Do you require UHN International to provide assistance with accommodations, transportation within Toronto, and other concierge services? *UHN International will provide cost estimate. All services are to be paid by patient or insurer.*	**Concierge services required: [ ] Yes [ ] No** **Accommodations: [ ] Yes [ ] No** **Travel: [ ] Yes [ ] No** **Other (please specify):**

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, specify 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.

Patient Signature: _____ **Date: _____**

Witness Signature:_____ **Date: _____**

UHN Toronto General Toronto Western Princess Margaret Toronto Rehab
INTERNATIONAL

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

Current Medications & Dosages:
Additional Comments:

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.

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.

Signature of Referring Physician and Office Stamp

Referring Physician Signature:

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:_____ **Date:** _____

OFFICE STAMP OF REFERRING PHYSICIAN