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 (UHN), please submit forms to the International Patient Program (IPP) by **email to ipp@uhn.ca or fax to 416-603-5406.**

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

□ Completed IPP Application with signatures from home country physician and patient, including all consent forms.
□ Section II filled out and signed by your home country physician or a referral letter stating why patient is seeking care at UHN.
□ Current medical records, in **English**, including lab reports, diagnostic reports/discs, and notes from the home country physician and hospitals.

I. To be completed by the PATIENT or DESIGNATE

PATIENT INFORMATION	
Patient First Name and Last Name:	**Date of Birth (DD/MM/YYYY):**
Gender: ☐ **Male** ☐ **Female** ☐ **I prefer not to say** **Permanent Address:**	**Home Telephone #:** **Mobile Telephone #:** **E-mail Address:**
Electronic Communication: *I understand that all electronic communication has risks and may not be secure. Messages sent to, or from your care provider may be seen or collected by third parties for their own purposes. UHN is not responsible for the security of your internet service providers, email domains, computer, tablet or cell phone or applications (programs) on your device. Electronic Communications may include: Email and SMS text messages.* **I consent to electronic communications with my UHN Care Team.** ☐ **Yes** ☐ **No**	
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 Yes, 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 Company:** **Name of Policy Holder:** **Policy Number:** **Contact Information (Phone/E-mail):**
☐	**Paid by Country or Embassy:**
☐	**Paid by Patient:**
☐	**Other (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, list language for interpreter services:**
Interpreter: **I have done my best to translate this form from English to _____ and will not divulge any information.**	**Interpreter Name:** **Date:** **Signature:**

INFORMATION AND AUTHORIZATION FOR COMMUNICATION WITH REPRESENTATIVE(S)	
Please list any representative(s) that will be providing support or accommodation. *Your representative will support **communication only** between yourself and your UHN care team. Your representative may share information with UHN under your direction but does not have the authority to make decisions for you about your care.*	**Name:** **Relationship:** **E-mail:** **Phone:** **Name:** **Relationship:** **E-mail:** **Phone:**

AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

This Authorization to Release or Obtain Health information section pertains to the disclosure or retrieval of your personal health information. ***This authorization may be withdrawn at any time and no further information will be shared. Please note if information has already been shared, that information cannot be retracted.***

I authorize UHN-International to discuss, disclose or obtain personal health information relating to my care at University Health Network to:

☐ **Insurance** ☐ **Lawyer** ☐ **Care Provider**

☐ **Other(Family, Friend, Spouse etc).** ** **If Other, please specify relationship to patient:** _____

Relating to treatment period for: _____

Recipient Name: **Relationship:** **Phone:** **E-mail:** **Fax:**	**Recipient Name:** **Relationship:** **Phone:** **E-mail:** **Fax:**
Print Patient Name/Substitute Decision Maker: **Signature and Relationship (if applicable):** **Date:**	**Print Name of Witness:** **Signature of Witness:** **Date:**

II. To be completed by the referring home country PHYSICIAN

A Referral Letter from the home country physician may also be submitted in lieu of Section II of this form.
Please note, this patient remains under the care of the referring physician until seen at UHN.

PHYSICIAN CONTACT INFORMATION	
Physician Name:	**E-mail:** **Phone Number:** **Fax:**
Address:	**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** ☐ **Prefer Not to Say**
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. If yes, please describe: ☐ The patient is being self-referred upon their own will.	
Treatment to Date:	

Recommended Treatment:
Current Medications & Dosages:
Additional Comments:

Please include copies of all supporting documents, test results, and 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 UHN's availability of expertise and capacity. Incomplete referrals will delay the booking process. UHN Physicians may reach out to you to further clarify information you have included in this document.

REFERRING PHYSICIAN SIGNATURE & OFFICE STAMP

I declare all the above information of this patient is correct and reflects their current health state. I have referred this patient for further investigation and treatment at UHN.

SIGNATURE OF PHYSICIAN: _____

DATE: _____

OFFICE STAMP:

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Governing Law and Jurisdiction Agreement
for Healthcare Organizations

This agreement ("Agreement") is entered into by and between _____ and
[Name of Patient]
UNIVERSITY HEALTH NETWORK MEDICAL SOLUTIONS (collectively, the "Parties").

Governing Law

The Parties hereby agree that:

a) all aspects of the relationship between _____ and UNIVERSITY HEALTH
[Name of Patient]
NETWORK MEDICAL SOLUTIONS (as well as their agents, delegates, employees, and any physicians and other independent healthcare practitioners providing medical or other healthcare and treatment to _____, or in association with UNIVERSITY HEALTH NETWORK MEDICAL
[Name of Patient]
SOLUTIONS, including without limitation any medical or other healthcare and treatment provided to _____, and
[Name of Patient]

b) the resolution of any and all disputes arising from or in connection with that relationship, including any disputes arising under or in connection with this Agreement, shall be governed by and construed in accordance with the laws of the province or territory of ONTARIO (other than conflict of laws rules) and the laws of Canada applicable therein.

Exclusive Jurisdiction

The Parties hereby acknowledge that the medical or other healthcare and treatment received by _____ from UNIVERSITY HEALTH NETWORK MEDICAL SOLUTIONS will be provided in the
[Name of Patient]
province or territory of ONTARIO, and that the Courts of ONTARIO shall have exclusive jurisdiction to hear any complaint, demand, claim, proceeding or cause of action, whatsoever arising from or in connection with that medical or other healthcare and treatment, or from any other aspect of the relationship between _____ and UNIVERSITY HEALTH NETWORK MEDICAL SOLUTIONS.
[Name of Patient]

_____	_____
SIGNATURE OF PATIENT or SUBSTITUTE DECISION MAKER	SIGNATURE OF WITNESS
_____	_____
PRINTED NAME	PRINTED NAME
_____	_____
DATE	DATE

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CONDITIONS OF ACCEPTANCE AS A PATIENT

(Non-Residents of Canada or Uninsured Canadian Residents)

As a Canadian hospital, it is the policy of the University Health Network (UHN) that all patients seen or treated on an elective basis that do not have Canadian federal or provincial health insurance must prepay all known hospital fees before being accepted as a patient. We may accept private insurance coverage in lieu of prepayment for such patients once approved by the UHN Medical Solutions International Patient Program department of UHN and once coverage is pre-certified in writing directly by the insurer. In certain cases, it may be necessary to see patients and perform certain testing and investigation before the known treatment plan can be developed. In such cases, UHN will estimate what the likely hospital fees related to the investigation and likely treatment plan will be and they must be paid and received by UHN before any further investigations and treatments start.

CONDITIONS:

1. Prepayment or approval of private insurance coverage is not a guarantee or a commitment to proceed with any hospital visit, nor does this obligate UHN to provide treatment if a treatment plan is developed.
2. Treatment at UHN will only proceed if all of the estimated hospital fees for the known treatment plan are paid, or private insurance approved, 14 business days in advance of the first date of service.
3. University Health Network reserves the right to decline treatment of such patients that are willing to pay for services if:
   - Placing the patient on the service waiting list would unreasonably prolong the waiting time for Insured Ontario and Canadian residents;
   - Resources for the required service are not available.
4. Regardless of what the estimated fees are, patients will only be charged the related hospital fee for actual services rendered at UHN. See related hospital estimate.

Signing below indicates your understanding and agreement to abide by these conditions.

Return the signed original document to:

University Health Network - International Patient Program
399 Bathurst Street, Krembil 4KD-401
Toronto, ON, M5T 2S8, Canada
Fax: 416-603-5406 Email: ipp@uhn.ca

SIGNATURE OF PATIENT or SUBSTITUTE DECISION MAKER	SIGNATURE OF WITNESS
PRINTED NAME	PRINTED NAME
DATE	DATE

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NOTIFICATION OF CHANGE IN STATUS AGREEMENT

Please note that if you are in the process of obtaining OHIP coverage or permanent residency in Canada you must provide this information (including the status of your OHIP coverage application) as a part of your application.

International fees are in effect until UHN Medical Solutions International Patient Program is provided with appropriate official documentation as to any change in your status.

In order to avoid incurring International fees, you must provide the relevant official documentation to UHN Medical Solutions at least 2 weeks prior to any scheduled services. Please note that no retroactive requests with respect to the reversal of International fees will be honored under any circumstances.

I, _____ have read and understand the above information and consent.

[Name of Patient]

_____	_____
SIGNATURE OF PATIENT or SUBSTITUTE DECISION MAKER	SIGNATURE OF WITNESS
_____	_____
PRINTED NAME	PRINTED NAME
_____	_____
DATE	DATE