HCA Referral Form

To confirm a referral to HCA has been made, it is essential that this form is faxed to HCA International Business on +44(0)20 7759 3825 AND that the patient presents a copy of this form at all HCA facilities at Registration

1.ABOUT THE PATIENT

Title	First Name	Family / Last Name	
		Male ☐: Female ☐	Nationality

Previously treated at a HCA Hospital? Yes ☐: No ☐ 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

Referring Doctor:

Referrers Contact Details Address Phone Fax Email	Confirmation of deposit (if applicable) ☐ Amount £ Quotes given £

3. ABOUT THE TREATMENT SOUGHT

Reason for referral: 2nd Opinion ☐: Appointment with Doctor ☐: Admission to hospital ☐:

Other – specify ☐

Main complaint / diagnosis / speciality sought

Medical report provided ☐ Number of Pages: Medical Report to follow ☐ X-rays provided ☐ X-rays to follow ☐

4. INFORMATION PROVIDED BY

HCA Referral Form

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1.ABOUT THE PATIENT

Title	First Name	Family / Last Name	
		Male ☐: Female ☐	Nationality

1. How will the account be settled?

Patient ☐:

Family ☐:

Company or sponsor ☐: State name:

Letter of guarantee provided Yes ☐: No ☐: Not applicable ☐.

By **Bank Transfer**

Please provide details of the paying Bank to include account holder, account number and sort code:

By **Banker's Draft**

Please provide details of the paying Bank to include account holder, account number and sort code:

By **Credit Card**

Please provide details of the card

By **Cash payment** ? Patient ☐: Family ☐: Company:Other sponsor ☐:

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 ☐

Doctors signature:	Date of Referral:

I certify that I have given the patient a copy of the completed form and certify that the information on this form has been checked with the patient or patient's representative.

I have explained to the patient or patient's representative that the purpose of recording and transmitting this information is
a) to support the referral request for treatment at a HCA facility,
b) if the application is approved, to provide those healthcare services including arranging appointments, travel, visas and accommodation and
c) to release medical record information about the patient for the purposes of facilitating treatment.

The patient or patient's representative has been made aware by you that they may withdraw consent at any time by contacting International Business. I confirm that I have given the patient a copy of the completed form.

Completed by (print)	Date
Signature of referral advisor	Date
Received by (HCA staff member)	Date
Actioned / Response made by	Date
Nature of action / response e.g. Visa arranged, flight booked, confirmation faxed.	
Follow up action required	
Follow up action by	Date