

?

**This form only works when javascript is active.  
Please change your browser settings.**

## **International Treatment Inquiry**

Dear patient, dear requestor,

Please note that we cannot deal with your inquiry unless you provide us with this form completed in English or German and the necessary medical reports in English or German.

**Please complete this form in English or German.**

### **Patient Data corresponding with your Passport data**

Please select

Title

First

name\* ERROR

Last

name\* ERROR

Gender\* ERROR

Date of birth

(DD.MM.YYYY)\* ERROR

Address

Zip code and city

Country\* ERROR

Phone

Fax

E-Mail\* ERROR

Contact person

(if different from  
patient)

Do you require visa  
assistance?

(invitation for the  
embassy)      Yes    No

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## Medical Information

1. **Disease(s) / Symptom(s) to be treated\*** ERROR

2. **What do you expect from your appointment / treatment in Heidelberg (specific indication / desired treatment)?\*** ERROR

3. **Select specialty department (only indicate if known)**

4. **Desired appointment date (DD.MM.YYYY)** ERROR  
Earliest possible appointment date

**Copies of the required medical documents (no originals)\*** ERROR

I will send you the copies of the medical documents along with this form via e-mail.  
(only data < 2MB; please do not send zip-, rar-, or bitmap-files) ERROR

5.

I will send you the copies of the medical documents via conventional mail.

I will send CT scans on CD Rom via conventional mail

I/the patient do(es) not suffer from any disease;

I desire an appointment for an out-patient check-up in the specialty department(s) indicated above.

6. **Which diagnostic tests were performed during the last 3-6 months? (please provide us with essential reports in English or German)**

MRI

CT

PET-CT

Ultra sound

X-ray

Angiography

Bronchoscopy

Other ERROR

**Laboratory tests**

Routine tests (blood count, etc.)

Special tests ERROR

**Histology** ERROR

Histological test; Tissue sample taken on (DD.MM.YYYY):

**7. Which treatments have been performed for the disease(s)/symptom(s) mentioned above?**

To date no treatment has been performed.

<b>Kind of Treatment</b>	<b>Description (Operation, medication, irradiated body part, etc.)</b>	<b>(Approximate) Duration</b>	<b>Ongoing</b>
		<b>On/From (MM.YYYY)</b>	<b>To (MM.YYYY)</b>
ERROR	Operation / Intervention (e.g. bronchoscopy)		
ERROR	Drug Therapy (e.g. Chemotherapy other medication)		
ERROR	Irradiation please add previous radiation treatment protocols		
ERROR	Other		

**8. Please indicate further relevant diagnoses:**

**9. Do(es) you/the patient have any infections at present?\*** ERROR

Unknown  
No  
Yes  
Description  
Pathogenic agent (if known)

**10. Do(es) you/the patient have any open wounds at present?\*** ERROR

Unknown  
No  
Yes  
location

**11. Please indicate your / the patient's present mobility status?\*** ERROR

not limited  
often / usually dependent on a wheel chair  
(partially) bedridden  
in intensive care unit

**12. Additional information on your medical condition which requires attention (max. 400 characters) [...]**

**13. Method of Payment**

Self pay cash credit card  
Transfer  
International insurance (must be Thoraxklinik contracted)  
Government or embassy sponsored

**How did you learn about Thoraxklinik Heidelberg ? (check all that apply)**

Internet  
Treating physician/hospital  
Family members/friends  
Business partners  
Employer  
Heidelberg University Hospital staff member  
Press releases  
Embassy/Governmental institution  
Health insurance  
Other: ERROR

I would like a copy of the inquiry to my e-mail indicated above.



Please wait while your request is being processed. If documents are being uploaded, the process can be prolonged.