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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

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 <u>required medical documents</u> (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.

	Kind of Treatment	**Description (Operation, medication, irradiated body part, etc.)**	**(Approximate) Duration On/From (MM.YYYY)**	**To (MM.YYYY)**	**Ongoing**
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.