Bupa Cromwell Hospital

International Patient Centre - Referral Form 1 of 2

To confirm a referral to Bupa Cromwell Hospital has been made, it is essential that this form is faxed to our International Patient Centre on +44(0)20 7835 2480 or emailed to international.relations@cromwellhospital.com . Patients are requested to bring a copy of this referral form with them to the hospital for their first appointment or on admission.

About the patient

Title	First name	Last name	
		Gender Male ☐ Female ☐	Nationality
Date of birth	Email address		
Home address		London address if known In London from (date)	
Contact telephone number		Is this Home ☐ Work ☐ Mobile ☐ Other ☐	
Other unique identifier e.g. Passport Number			
Accompanied? By mother ☐ By father ☐ By child ☐ Other ☐ Unaccompanied ☐		If Yes, name of companion	

Payment details

Who will settle the account? Patient ☐ Family ☐ Embassy sponsor ☐ Company ☐ Adviser ☐ Other sponsor ☐	Embassy / sponsor / advisor name
Letter of Guarantee provided? Yes ☐ No ☐ Not applicable ☐	Comments
How will the account be settled? Bank Transfer ☐ Bank Draft ☐ Cheque ☐ Cash ☐	Details of paying bank, include account holder, account number and sort code.

Special requests

Interpreter ☐ If Yes, language	Assitance ☐ with access	Advice on holiday accommodation ☐	Advice on Flights ☐
Visa to be arranged Yes by Bupa Cromwell Hospital ☐ Yes by self ☐ Not applicable ☐ Other ☐		Please specify Other	

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About the patient

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		Gender Male ☐ Female ☐	Nationality

About the referral source

Referral advisor name	
Referral advisor code	Date of referral
Referral advisor current contact details Telephone Fax Email	Confirmation of deposit ☐ Amout £ Quote given £

About the treatment sought

Reason for referral		Main complaint / diagnosis / specialty sought	
2nd opinion ☐	Appointment with doctor ☐	Medical report provided ☐ No. of pages	X-rays provided ☐
Other ☐	Admission to hospital ☐	Medical report to follow ☐ _____	X-rays to follow ☐

Information provided by

I understand that the purpose of recording and transmitting this information is:

a) to support the referral request for treatment at Bupa Cromwell Hospital

b) if the application is approved, to provide those healthcare services including the scheduling of appointments, arranging travel, visas and accommodation and

c) to release medical record information about the patient for the purposes of facilitating treatment.

I understand that I may withdraw consent at any time by contacting the International Patient Centre.

Completed by (print)	Date
Received by (BCH 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