HELIOS International Office – Patient Checklist

PATIENT DATA

Last name:	**First name:**	
Address:	**Zipcode + City:**	
DOB:	**Nationality:**	
Phone:	**Mobile:**	
Email:		
Health insurance:		
Which languages do you speak?		
Do you need a translator?	**No** ☐	**Yes** ☐
How do you know of HELIOS?		

ACCOMPANYING PERSON

Last name:	**First name:**	
DOB:	**Nationality:**	
Phone:	**Mobile:**	
Email:		

MEDICAL INFORMATION (please forward all medical imaging and medical documents)

Health problems/complaints:		
Diagnosis (medical report):		
Since when do you know about your diagnosis?		
Do you have any medical imaging? (MRI, CT, x-ray, ultrasound, etc.)	**No** ☐	**Yes:**
Did you have any surgeries in the past?	**No** ☐	**Yes:**
Do you have any form of metal in your body?	**No** ☐	**Yes:**
Do you take any anticoagulants/blood thinner?	**No** ☐	**Yes:**
Do you take any other medication?	**No** ☐	**Yes:**
Are you diabetic?	**No** ☐	**Yes:**
Do you have any allergies?	**No** ☐	**Yes:**
Which type of treatment are you looking for? Diagnostics, surgery, rehabilitation?		
Do you prefer a specific HELIOS Hospital?	**No** ☐	**Yes:**

FURTHER INFORMATION (e.g. epicrisis, travel & passport data, bank account information, etc.)