



SURGICAL TOURISM CANADA INC.

Healthcare without borders

Attending Physician's Statement

This form serves to provide STC with information pertaining to your patient's decision to receive surgical treatment at one of our Partner Hospitals in India or the USA

PATIENT CONSENT

Name of Patient (print) _____ Date of Birth (day/month/year) _____

Street _____ City _____ Province _____ Postal code _____

I hereby authorize the release to Surgical Tourism Canada any information or records relevant to the condition _____ for which I am seeking treatment through STC.

Date (day/month/year) _____ Signature of patient _____ Tel _____
(The patient is responsible for securing this information and any fees her/his physician may charge.)

PHYSICIAN STATEMENT

When did the symptoms first appear? (day/month/year) _____

When was the condition first diagnosed? (day/month/year) _____

Has the patient been placed on a surgical waitlist? No ___ Yes ___ If yes, anticipated month/year of surgery _____

Have any further complications developed since the condition was diagnosed? No ___ Yes ___ If yes please explain _____

Symptoms (please list) _____

Please list co-morbidity condition(s) _____

Please attach any copies of reports or diagnostic tests pertaining to the condition being treated.

The patient initiated request for travel.

The patient of her/his own volition having chosen to receive elective surgery in India or the US and will need to travel there by plane over a two-day period. All travel has inherent risk of delays or accidents in transit, pain or discomfort upon movement, and limited medical capacity of transportation units that may limit available care in the event of a crisis. Please provide your opinion about the suitability of patient's condition for taking on such travel.

There is no reasonable likelihood of deterioration from or during travel to India. Agree ___ Disagree ___

The patient may be at risk of deteriorating from or during travel. Please explain _____

Based upon my examination of the patient and the information available to me at the time of examination, I certify that the risks of travel are outweighed by the benefits reasonably anticipated from proper care at the receiving facility.

Physician's Name (print) _____ Telephone number _____

Street _____ City _____ Province _____ Postal code _____

Date _____ Signature _____ MD Certified specialist Yes ___ No ___ Please specify

Suite 400,601 W. Broadway, Vancouver, BC, V5Z 4C2

T: 604-575-4316, F: 778-574-7253

Toll Free 1-877-871-4315

Email: info@surgicaltourism.ca

www.surgicaltourism.ca