

TM



INTERNATIONAL PATIENT REGISTRATION FORM

FACILITATION CENTRE \_\_\_\_\_ Territory \_\_\_\_\_

*(To be filled by Patient/relative only)*

If the Form is filled by the relative, kindly mention relationship with the patient \_\_\_\_\_

Provisional Diagnosis/Medical History \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Referred By : \_\_\_\_\_ Specialty : \_\_\_\_\_ Date: --  
(dd) (mm) (yyyy)

Treatment Sought: \_\_\_\_\_

Expected date of arrival: -- Expected date of Admission: --  
(dd) (mm) (yyyy) (dd) (mm) (yyyy)

Name of Patient - Mr./Ms./Mrs. \_\_\_\_\_

Age: \_\_\_\_\_ Sex:  (Male)  (Female)  (Other) Nationality: \_\_\_\_\_  
*(Please choose the appropriate option)*

Blood Group: \_\_\_\_\_

Passport No.: \_\_\_\_\_ Date of issue: -- Date of expiry: --  
(dd) (mm) (yyyy) (dd) (mm) (yyyy)

Father's/Husband's Name: \_\_\_\_\_

Local Guardian Name Accompanying the Patient : \_\_\_\_\_

Address: \_\_\_\_\_

State: \_\_\_\_\_ PIN/ZIP Code: \_\_\_\_\_ Country: \_\_\_\_\_

Phone (Res.): \_\_\_\_\_ Phone (Off.): \_\_\_\_\_ Mobile: \_\_\_\_\_

E-mail: \_\_\_\_\_ Fax: \_\_\_\_\_



## INTERNATIONAL PATIENT REGISTRATION FORM

*(In case of Emergency Family members to be contacted)*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

State: \_\_\_\_\_ PIN/ZIP Code: \_\_\_\_\_ Country: \_\_\_\_\_

Phone (Res.): \_\_\_\_\_ Phone (Off.): \_\_\_\_\_ Mobile: \_\_\_\_\_

E-mail: \_\_\_\_\_ Fax: \_\_\_\_\_

Expected date of arrival: --  
(dd) (mm) (yyyy)

Expected date of Admission: --  
(dd) (mm) (yyyy)

I hereby declare that the facts stated above are true to the best of my knowledge and belief. I have no objection to my health records at being made available to the Hospitals /and or Doctors who will be treating me as also on the websites of the Hospital or that of Revita Healthcare.

\_\_\_\_\_  
**Signature/impression of the Patient/Relative**

### (FOR OFFICE USE ONLY)

Procedure/Treatment to be undergone : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Quotes: \_\_\_\_\_

Total Quotes : \_\_\_\_\_

Consultation through Telemedicine:  (Yes)  (No)

Medical documents attached :  (Yes)  (No)

Preferred Affiliated Hospital Name: \_\_\_\_\_

Preferred Specialist, if any: \_\_\_\_\_

Tentative date of visit to Affiliate Hospital : --  
(dd) (mm) (yyyy)

Date: \_\_\_\_\_ Co-ordinator's Name & Signature \_\_\_\_\_