APPLICATION FORM

Treatment request

Patient

Have you previously been a patient at Sahlgrenska University Hospital/Sahlgrenska International Care AB?

☐ YES ☐ NO

LAST NAME: ______________________

FIRST NAME: ______________________

DATE OF BIRTH: (year) ________ (month) ________ (day) ________

GENDER ______________________

CITIZENSHIP: ______________________

ADRESS:

(Street/Box) ______________________

(Zip code and City) ______________________

(Country) ______________________

(Phone) ______________________ (Mobile) ______________________

(E-mail) ______________________

Fax ______________________

PRIMARY LANGUAGE ______________________

If additional space is needed, continue on a separate sheet of paper.

Contact person

If you have appointed someone to handle your application and be our contact person, please fill in this section.

LAST NAME: ______________________

FIRST NAME: ______________________

ADRESS:

(Street/Box) ______________________

(Zip code and City) ______________________

(Country) ______________________

(Phone) ______________________ (Mobile) ______________________

(E-mail) ______________________

Fax ______________________

Contact information to physician in the home country or country where the patient has been treated

CONTACT INFORMATION

Medical Care

Please provide us with information about your diagnosis, symptoms and treatment history.

DIAGNOSIS AND SYMPTOMS

If additional space is needed, continue on a separate sheet of paper.

REASON FOR REQUESTING MEDICAL CARE IN SWEDEN
If applicable, please name the requested treatment

I'M INTERESTED IN

- [ ] Treatment
- [ ] Investigation
- [ ] Written second opinion
- [ ] Other

HOW WILL THE MEDICAL CARE BE FINANCED

- [ ] Payment guarantee from public authority
- [ ] Payment guarantee from insurance company
- [ ] Private payment (pre payment)
- [ ] An E112 form (S2) for planned medical care in another EU-country

Other

HOW DID YOU GET IN CONTACT WITH SAHLGRENSKA INTERNATIONAL CARE?

- [ ] Relative/friend in Sweden
- [ ] Recommendation/referral by physician in the home country
- [ ] Recommendation/referral by physician in Sweden
- [ ] Internet

Sahlgrenskaic.com

- [ ] Health insurance
- [ ] Embassy/governmental institution
- [ ] Other, please specify below

PROCESSING OF PERSONAL DATA

THE COLLECTION AND PROCESSING OF PERSONAL DATA IS REGULATED IN THE GENERAL DATA PROTECTION REGULATION (GDPR)

Sahlgrenska International Care processes personal data in accordance with EU regulation 2016/679 of the European Parliament and of the Council. This regulation is referred to as the General Data Protection Regulation (GDPR).

We process personal data to fulfill our assignment as a care provider for international patients. The data will be handled by employees within Sahlgrenska International Care and by the caregivers within Region Västra Götaland involved in processing your request for planned medical care.

The information that we intend to collect is name, date of birth, address and data concerning your medical condition and planned treatments. It will be stored in our file system.

Personal information required to make hotel reservations or other services related to your medical care may be disclosed to external recipients. If necessary for continued care or invoicing purposes personal data will be transferred to concerned authorities and/or caregivers abroad.

We only store your personal data for as long as is necessary for the purpose of the processing, or as long as is required by law.

You can contact info@sahlgrenskaic.com to receive more information about what data we store about you or to ask for data to be erased, transferred, limited or corrected.

PLEASE SEND COMPLETED AND SIGNED FORM TOGETHER WITH COPIES OF RECENT MEDICAL RECORDS IN ENGLISH OR SWEDISH TO:

Sahlgrenska International Care
Box 7163
402 33 Gothenburg, Sweden

If additional space is needed, continue on a separate sheet of paper.