SickKids®

LAST NAME	(FIRST)
MRN	VISIT NUMBER
DATE OF BIRTH DD-MM-YYYY	SEX

FOR HOSPITAL STAFF TO ENTER DATA OR AFFIX LABEL

International Patient Program

Medical Second Opinion Referral Form

Please complete this form in BLOCK letters and in ENGLISH only

SECTION 1: PATIENT INFORMATION

Last name	First name	Middle name
Date of birth (DD-MM-YYYY)	Country of birth	Country of citizenship
Gender ☐ Male ☐ Female ☐ Other	Language(s) spoken at home	English interpreter needed? ☐ Yes ☐ No

Home address

City	Province / State	Country	Postal code / Zip code

Home telephone number	Email address

Primary diagnosis (if unknown, list unknown)

Why do you want a Medical Second Opinion? What are the current clinical questions you have?

Are you requesting molecular testing / pathology review?	Are you requesting a diagnostic imaging review?

This Medical Second Opinion will be used by:

☐ Local care team ☐ Third party (i.e., insurance company) ☐ Personal use

☐ Other (specify): _____

Your referral will be reviewed by the physician for acceptance before the Medical Second Opinion can be provided.

Is the timeline for receiving the Medical Second Opinion flexible according to physician expert availability? ☐ Yes ☐ No

Indicate your requested timeline for receiving the Medical Second Opinion:

☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ 4 weeks ☐ Other (specify): _____

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SECTION 2: PARENT / LEGAL GUARDIAN INFORMATION

Name of parent / legal guardian 1	Relationship to patient	Email address
Home telephone number	Mobile number	Work number
Name of parent / legal guardian 2	Relationship to patient	Email address
Home telephone number	Mobile number	Work number

Who is the primary contact for this patient?

☐ Parent / legal guardian 1 ☐ Parent / legal guardian 2 ☐ Other (specify):

Home address of primary contact ☐ Same as patient address

City	Province / State	Country	Postal code / Zip code
Home telephone number		Email address	

SECTION 3: PAYMENT INFORMATION

Indicate who will be financially responsible for payment.
Check the appropriate box and provide details.

☐ Insurance or Foreign Government or other Third Party Organization

Name of Payor (Insurance or Foreign Government or other)			Insurance Policy holder
Insurance Policy number	Insurance Group number		Maximum coverage amount in USD($)

Payor Business Address (Insurance Company or Foreign Government or other address)

City	Province / State	Country	Postal code / Zip code
Telephone number	Fax number		Email address

Third Party Administrator Name and Contact (if applicable)

☐ Self-pay by parents or other payor
Please provide the information below regarding the person who will be financially responsible for payment, if different from parent.

Last name	First name	Initial(s)	Relationship to patient

Home address

City	Province / State	Country	Postal code / Zip code
Telephone number	Fax number		Email address

☐ Humanitarian Fund Assistance Request

If you are in need of financial assistance, please complete the application for Humanitarian Fund Assistance Request form.

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SECTION 4: MEDICAL SUMMARY

This medical summary is provided by: ☐ Family ☐ Referring physician

State clinical history / timeline and submit all relevant medical information in English, including up-to-date **(within the past 6 months)** medical history, diagnosis, height, weight, allergies, vaccinations, results of tests / procedures, medications, and current symptoms. If the space below is insufficient, feel free to attach documents.

The International Patient Program is unable to accept any supporting medical records obtained more than 6 months prior to submission of this referral, unless the records older than 6 months are relevant and required for the review.

Are there other underlying medical conditions that are relevant to this Medical Second Opinion in addition to the primary and/or secondary clinical diagnosis?

☐ Request for a specific SickKids physician

I request that the opinion to be carried out by:

Name of physician: _____ Division / Department: _____

☐ Request the International Patient Program to appoint a physician to provide the opinion

SECTION 5: REFERRING PHYSICIAN (if applicable)

Name of referring physician		Specialty	
Name of referring hospital		Address of referring hospital	
City	Province / State	Country	Postal code / Zip code
Telephone number	Fax number	Email address	

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CONFIRMATION OF AGREEMENT

By signing below, I am accepting responsibility for

(a) providing to SickKids the requested information of patient's condition for this Medical Second Opinion,

(b) providing or facilitating the provision of care.

Print name of physician	Physician signature	Date (DD-MM-YYYY)

SECTION 6: PARENT / LEGAL GUARDIAN AGREEMENT AND SIGNATURES

This Medical Second Opinion will be used by the individuals indicated in Section 1 and cannot be used for legal purposes.

The International Patient Program recommends all medical documentation (e.g., medical reports, scans, X-rays, echo tapes, etc.) be photocopied prior to submitting to The Hospital for Sick Children. If original medical records are submitted, The Hospital for Sick Children is not liable for their loss or damage, or for costs incurred to replace the submitted medical records.

Please check appropriate box below:

- ☐ I am submitting original medical documentation.
- ☐ I am submitting photocopied medical documentation.

CONFIRMATION OF AGREEMENT

By signing below, I hereby certify that all information provided and enclosed is true and correct and submit the medical documentation in full agreement of the above stated terms. Any application containing false information will be null and void.

Printed name of parent / legal guardian	Parent / legal guardian signature	Date (DD-MM-YYYY)