Memorial Sloan-Kettering International Center

If patient is a US Citizen or "Green Card" Holder, please call our Physician Referral Service at 1-800-525-2225

Fax this page to: +1-212-639-4938

Include relevant clinical reports (in English) regarding this patient

Do not schedule travel or come to MSKCC until an appointment is confirmed by the International Center

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Patient Name ____________________ ____________________ ___ ___/___/___ (Month Day Year)

Last First Sex Date of Birth

Citizenship ____________ Home Address ______________________________

City ____________ State ____________ Postal Code ________ Country ____________

Phone ______________________________ Fax ______________________________

Country Code / Area Code / Number Country Code / Area Code / Number

Cell ______________________________ Email ____________________@________

Country Code / Area Code / Number

- -

Contact Name ______________________________ Email ____________________@________

Name of individual we can contact on patients behalf

Phone ______________________________ Fax ______________________________

Country Code / Area Code / Number Country Code / Area Code / Number

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> This section is to be completed by a Physician that is not a friend or family member <

- Diagnosis: ____
- Date of diagnosis: ____/____/____ (Month Day Year)
- What treatment modalities has the patient received and corresponding dates?

  ____ ____/____ (Month Year)

  ____ ____/____ (Month Year)

  ____ ____/____ (Month Year)

- Please note any other medical problems this patient may have (Heart, Lung, GU, GI, CNS):

  ____

  ____

- Current treatment plan being recommended or reason for possible medical travel:

  ____

- Is patient medically stable for travel: [ ] Yes [ ] No
- Recommend patient obtain: [ ] Mail Review [ ] Treatment

  [ ] Consultation Only – *desired dates*: ___/___/___ to ___/___/___

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Physician Name ____________________ Physician Signature ____________________

Physician Phone ____________________ Date ___/___/___