Memorial Sloan Kettering Cancer Center

BOBST INTERNATIONAL CENTER SERVICE REQUEST FORM

Citizenship _____ **Does the patient have a visa?** Yes ☐ No ☐

What is the patient's primary language?_____ **Will the patient require a translator?** Yes ☐ No ☐

Is the patient currently admitted to a hospital? Yes ☐ No ☐ **Is the patient medically stable for travel?** Yes ☐ No ☐

Has the patient traveled in the last 21 days to one of the following countries: Guinea, or Sierra Leone? Yes ☐ No ☐

Patient Name _____ (Last) _____ (First) _____ (Sex) _____/_____/_____ (M D Y) (Date of Birth)

Home Address _____

City _____ **State** _____ **Postal Code** _____ **Country**_____

Phone _____ (Country Code / Area Code / Number) **Fax** _____ (Country Code / Area Code / Number)

Cell Phone _____ (Country Code / Area Code / Number) **E-mail** _____@_____

Name of an individual we may contact on the patient's behalf:

Contact Name: _____ (Last First) **Phone:** _____ (Country Code / Area Code / Number)

Relationship to patient: _____ **E-mail:** _____@_____

Please check ☑ which service you are interested in:
(Each service is described in the MSK IC Service Letter)

On-site services
- ☐ On-site consultation
- ☐ On-site consultation and treatment

Remote services
- ☐ Mail Review
- ☐ Pathology Review
- ☐ Radiology Review
- ☐ Integrative Review

Please note in some cases the requested service may not be the most appropriate, our clinical team will advise which service may be available in these instances.

Is there a diagnosis of cancer or is this a recurrence of a previously diagnosed and treated cancer?

☐ No Diagnosis Yet ☐ Newly Diagnosed ☐ Receiving Treatment ☐ Recurrence

What is your diagnosis? _____

If availability permits, the requested dates for an appointment are: _____/_____/_____ (M D Y)

If availability permits, the requested physician is:_____

The following documentation is required to proceed with all services. Please send the most recent information. **ALL** submitted medical information **MUST** be translated into **ENGLISH. Please ensure the name of the patient, date of birth, date of procedure and the name of the hospital or institution are on all translated documents in English.**

- ☐ Copy of the patient's passport
- ☐ Physician Medical Summary detailing your condition and treatment
- ☐ Laboratory reports
- ☐ Pathology reports (Please include a copy of the original report with the English translation)
- ☐ Radiology reports
- ☐ Surgical reports
- ☐ Chemotherapy administration records
- ☐ Radiation therapy records
- ☐ Insurance information: (If applicable, a copy of the card front and back)

Additional information regarding the patient's treatment or service request:

_____

_____

_____

_____

Memorial Sloan Kettering Cancer Center

Credit Card Payment Authorization for Remote Services

Telephone: +1-212-639-4900 **Fax: +1-212-639-4938**

By signing below, I hereby authorize the Memorial Sloan-Kettering Cancer Center to charge my Credit Card for a mail review or other related remote service that may be provided at Memorial Sloan-Kettering Cancer Center.

Indicate type of credit card to be charged (we do not accept Debit Cards):

☐ American Express ☐ MasterCard ☐ Visa ☐ Diners Club ☐ Discover

Credit Card Number: _____

Expiration Date: ____/____/____ CVN: _____

Name (as it appears on the credit card): _____ Today's Date: ____/____/____

Signature of authorized cardholder: _____

Patient Name: _____ Medical Record Number:_____

Comment: _ _____

Amount: _____

Cardholder's Business address: (*The Address where the credit card statements are mailed*)

Street: _____

City: _____ Country: _____

Postcode: _____

Credit Card Authorizations with your signature
May be sent to the MSK Bobst International Center
via fax: +1-212-639-4938 or via email: intnlprg@mskcc.org