**Return addresses**

eDialog: <https://svarut.ks.no/edialog/mottaker/983974724>

Paper mail: Helse Bergen HF, Enhet for utenlandsbehandling, Postboks 1400, 5021 Bergen

**Do no return by email.**

Application for treatment abroad

The Patients' and Users' Rights Act § 2-4 a second paragraph letter a

**PERSONAL INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Last name, First name: | | | National identity number (11 digits): |
|  | | |  |
| Address: | | Postcode: | City: |
|  | |  |  |
| Phone/mobile: | Email: | | County: |
|  |  | |  |

|  |  |  |
| --- | --- | --- |
| **When the patient is under 16 years of age** | | |
| Mother's name: | Mobile: | Email address: |
|  |  |  |
| Father's name: | Mobile: | Email address |
|  |  |  |

**MEDICAL INFORMATION**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Diagnosis: | | | | | | | | | | | Diagnostic code(s) (ICD-10): | | | | | | |
|  | | | | | | | | | | |  | | | | | | |
| The health care applied for (in Norwegian, and English if applicable): | | | | | | | | | | | Surgical procedure(s) (NCSP): | | | | | | |
|  | | | | | | | | | | |  | | | | | | |
| Medical urgency for treatment abroad (elaborate on the reasons): | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Has the patient been assessed as entitled to necessary health care in the specialist health service? | | | | | | | | | At which hospitals has the patient been assessed/treated? | | | | | | | | |
| Yes |  | No |  |  | | | | |  | | | | | | | | |
| Reasons for applying for healthcare abroad: | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Relevant place of treatment abroad (Name, address, department and treating doctor or contact person): | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Reasons for this choice of treatment: | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Is the treatment to be regarded as experimental? | | | | | | | | | | | | Yes |  | | | No |  |
| Is one (or more) companion(s) required for medical or treatment reasons? | | | | | | | | | | | | Yes |  | | | No |  |
| Reasons: | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Special considerations when choosing transport: | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Special needs: | | | | | | | | | | | | | | | | | |
| Tube feeding: | |  | | | Wheelchair: |  | | Oxygen: | |  | | | | | | | |
| Other: | |  | | | | | | | | | | | | | | | |
| Number of attachments: | | | |  | | --- | |  | | | | | Statement | | | Medical records | | | | | Other | | |
| Who is responsible for following up the patient in Norway after treatment abroad? | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Cost estimate for medical treatment: | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Approx. number of days stay: | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Any additional notes: | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Date: | | Patient's or guardian's signature: | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | | |
|  | | I consent that the Office of Treatment Abroad may collect and use my medical records from previous processing for its case processing. | | | | | | | | | | | | | | | |
| Date: | | When under treatment in Norway:  Signature of the responsible healthcarer: | | | | | | | | | | Tel: | |  | | | |
|  | |  | | | | | | | | | | | | | | | |
| Date: | | When applying from a hospital:  Signature of the head of department | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | | |