**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 |
|  |  |