Letter of Overseas Referral

This Letter of Overseas Referral Form has been approved by Argus, BF&M, CG, GEHI and HID (HIP and FutureCare).

Clear Form

Patient Last Name:	Patient First Name:
DOB (dd/mmm/yyyy):	Patient's language:
Address:	Email:
Phone (H):	Phone (C):
Insurance Company:	
Policy Number:	Certificate Number:
Referring Physician:	Physician Contact #:

Clinical Information

Diagnosis:

Reason for Overseas Referral:

☐ I have attached/faxed all supporting consult notes, including past medical history related to current condition.

Is this treatment/procedure available in Bermuda? ☐ Yes ☐ No	Referral Primarily Initiated by: ☐ Physician ☐ Patient/family
Date of admission to KEMH:	KEMH Department:

Urgency of Referral

☐ Emergent*	☐ Urgent**	☐ Non-Urgent

Referral Information ☐ Accepting provider/facility not identified

Name of receiving facility:

Name of receiving provider:

Appointment date (if known) (dd/mmm/yyyy):

Travel Requirements

Please choose the most appropriate method of travel based on the patient's current clinical status and/or medical requirements.

☐ **Air Ambulance**

Team required: ☐ Critical Care Team (MD/RN/RT) ☐ RN/RT

Special equipment on board for transfer:

☐ **Commercial Flight**

Wheelchair assistance required?	☐ No	☐ Yes
Medical Escort required?	☐ No	☐ Yes
O2 required on board?	☐ No	☐ Yes

Vaccination Status

☐ Fully vaccinated

☐ Partially vaccinated – next dose scheduled for (dd/mmm/yyyy):

☐ Unvaccinated, if yes, is there a medical exemption?

Travel Requirements (continued)
Any special seat accommodations required due to their medical condition, please specify:
Does the patient require a companion (family member) to travel? ☐ No ☐ Yes – please provide rationale:

I understand that should subsequent overseas treatment be required including follow-up visits, the health insurance provider may require documentation of medical necessity prior to the patient's departure.

Physician's Signature:	Date (dd/mmm/yyyy):

For Lady Cubitt Compassionate Association Use Only

Clear Section

Bermudian: ☐ Yes ☐ No– state nationality:

Estimated Duration of Treatment:

Recommendation of Advisor Committee: ☐ Approved ☐ Not Approved

Authorized Signature:	Date (dd/mmm/yyyy):