Medical Tourism Travel Intake Form

Complete, save, and upload this form to your secure patient folder. Do not email completed forms.

1 Patient / Primary Traveler Information

Primary contact details and identity information

FIRST NAME

MIDDLE NAME

LAST NAME

DATE OF BIRTH (DD/MON/YYYY)

GENDER

Select...

PREFERRED LANGUAGE

EMAIL ADDRESS

MOBILE PHONE

CITIZENSHIP

COUNTRY OF RESIDENCE

HOME ADDRESS

2 Passport, Visa, and International Travel Details

Information to support travel planning and document review

NAME EXACTLY AS ON PASSPORT

PASSPORT NUMBER

PASSPORT EXPIRY (DD/MON/YYYY)

PASSPORT ISSUING COUNTRY

SECOND PASSPORT / DUAL

Select...

VISA REQUIRED FOR DESTINATION

Select...

KNOWN / TRUSTED TRAVELER NUMBER

TRAVEL INSURANCE / POLICY NO.

VISA, ENTRY, CUSTOMS, OR PASSPORT NOTES

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3 Medical Travel Coordination

Non-clinical planning details related to the medical trip

DESTINATION COUNTRY

DESTINATION CITY

HOSPITAL / CLINIC / PROVIDER

PROCEDURE / TREATMENT TYPE

TARGET DEPARTURE (DD/MON/YYYY)

TARGET RETURN (DD/MON/YYYY)

DATE FLEXIBILITY

Select...

MOBILITY / ACCESSIBILITY NEEDS

Select...

INTERPRETER / CAREGIVER / NURSING

Select...

ADDITIONAL MEDICAL TRAVEL PLANNING NOTES

4 Air Travel Preferences

Airports, airline choices, seating, loyalty numbers, in-flight needs

PREFERRED DEPARTURE AIRPORT

ALTERNATE DEPARTURE AIRPORT

PREFERRED ARRIVAL AIRPORT

PREFERRED AIRLINE

Select...

PREFERRED CABIN CLASS

Select...

SEAT PREFERENCE

Select...

FREQUENT FLYER PROGRAM

FREQUENT FLYER NUMBER

CONNECTION PREFERENCE

Select...

IN-FLIGHT MEAL PREFERENCE

Select...

AIRPORT / AIRLINE ASSISTANCE

Select...

ADDITIONAL AIR TRAVEL NOTES

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5 Hotel and Accommodation Preferences

Preferred hotel partners, room setup, accommodation requirements

PREFERRED HOTEL PARTNER
Select...

HOTEL CATEGORY
Select...

ROOM TYPE
Select...

BED PREFERENCE
Select...

HOTEL BUDGET (PER NIGHT)

SMOKING PREFERENCE
Select...

HOTEL LOYALTY PROGRAM

HOTEL LOYALTY NUMBER

REQUESTED HOTEL AMENITIES

- ☐ Breakfast included
- ☐ Kitchenette
- ☐ Airport shuttle
- ☐ Hospital shuttle
- ☐ Laundry
- ☐ Accessible room
- ☐ Companion sleeping arrangement

ADDITIONAL ACCOMMODATION NOTES

6 Ground Transportation

Arrival, transfer, and destination transportation preferences

AIRPORT TRANSFER NEEDED
Select...

VEHICLE PREFERENCE
Select...

CHILD CAR SEAT NEEDED
Select...

GROUND TRANSPORT NOTES

7 Emergency Contact

Person to contact in case of travel disruption or emergency

FULL NAME

RELATIONSHIP

PHONE NUMBER

EMAIL ADDRESS

8 Family Members / Companions Traveling

Information for family members or companions traveling with the patient

Companion 1

FULL NAME

RELATIONSHIP

Select...

DATE OF BIRTH (DD/MON/YYYY)

PASSPORT NUMBER

CITIZENSHIP

SEAT PREFERENCE

Select...

PHONE

EMAIL

Companion 2

FULL NAME

RELATIONSHIP

Select...

DATE OF BIRTH (DD/MON/YYYY)

PASSPORT NUMBER

CITIZENSHIP

SEAT PREFERENCE

Select...

PHONE

EMAIL

Companion 3

FULL NAME

RELATIONSHIP

Select...

DATE OF BIRTH (DD/MON/YYYY)

PASSPORT NUMBER

CITIZENSHIP

SEAT PREFERENCE

Select...

PHONE

EMAIL

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9 Additional Preferences and Authorizations

Final preferences, communications, and acknowledgement

PREFERRED COMMUNICATION METHOD

○ Email ○ Phone ○ Text / SMS ○ WhatsApp

SPECIAL REQUESTS / ADDITIONAL NOTES

☐ I confirm that the information provided is accurate to the best of my knowledge and may be used for travel planning, hotel coordination, and logistics support related to my medical tourism journey.

PATIENT NAME (PRINTED)

SIGNATURE (TYPE FULL LEGAL NAME)

DATE (DD/MON/YYYY)