



Treatment Management Service Information Form

Date (yyyy/mm/dd)	Name	Gender <input type="radio"/> Male <input type="radio"/> Female	Birthdate (yyyy/mm/dd)	
Address		City	Province	Postal code
Area code/phone number		Other ( <input type="radio"/> Phone/ <input type="radio"/> Fax/ <input type="radio"/> Cell/ <input type="radio"/> E-mail)		Membership/policy number (if applicable)

(Please print or type. All information must be completed.)

Name of physician and/or specialist(s) \_\_\_\_\_

Phone number(s) \_\_\_\_\_ Other (fax/e-mail) \_\_\_\_\_

Current diagnosis \_\_\_\_\_

Required medical procedure(s) \_\_\_\_\_

Desired US location(s) of treatment (city/state) \_\_\_\_\_

Desired medical facility (if known) \_\_\_\_\_

Other relevant information (i.e. related medical history) \_\_\_\_\_

MEDICAL AUTHORIZATION

I hereby authorize my physician to provide OneWorld Medicare Inc. with any and all information regarding my current illness or injury, including any relevant medical history, consultations, medicines or treatment. A photocopy of this Authorization received from the patient or OneWorld Medicare Inc. shall be considered as effective and valid as the original.

Dated \_\_\_\_\_

Signed \_\_\_\_\_  
(PATIENT OR SPOUSE, PARENT OR GUARDIAN OF PATIENT)