



## PATIENT REFERRAL CONFIRMATION VOUCHER

DATE:

Please be kind enough to fill the form and forward it back to us by email: [healthcare@alohamaldives.com](mailto:healthcare@alohamaldives.com)  
or fax: +960-3341953

PATIENT DETAILS			
Name:	Title:		
Date of Birth:-	Passport no:-		
Contact No of Country of residence:			
Address:	Contact No in Sri Lanka:		
TYPE OF SICKNESS			
Cardio <input type="checkbox"/>	GYNAE <input type="checkbox"/>	DENTAL <input type="checkbox"/>	EYE <input type="checkbox"/>
ORTH <input type="checkbox"/>	LABOR <input type="checkbox"/>	DIABETIC <input type="checkbox"/>	ENT <input type="checkbox"/>
ACC <input type="checkbox"/>	SURGERY <input type="checkbox"/>	FERTILITY <input type="checkbox"/>	ANY OTHER <input type="checkbox"/>

SPOUSE / GUARDIAN DETAILS	
Name:	Contact Detail:
Your relationship to the patient:-	
We hereby agree to pay all charges of the hospital by :- Cash <input type="checkbox"/> Credit Card <input type="checkbox"/> VISA <input type="checkbox"/> MASTER <input type="checkbox"/> AMEX <input type="checkbox"/>	
Signed: .....	Date: .....

CONSULTANT DETAILS (If you have been Consulted Before)
Consultant Name: Doctor / Professor

If you have not consulted early and want us to recommend to a specialist
Please Tick : Yes <input type="checkbox"/> No <input type="checkbox"/>

REFERRED BY	
<input type="checkbox"/> Hospital	<input type="checkbox"/> Clinic

OTHER INFORMATION	
Patient to be picked up by ambulance at Airport:- <input type="checkbox"/> Yes <input type="checkbox"/> No	
Doctor Required:- <input type="checkbox"/> Yes	<input type="checkbox"/> No:
Nurse Required:- <input type="checkbox"/> Yes	<input type="checkbox"/> No:
If Doctor and Nurse is accompanied by patient:- <input type="checkbox"/> Yes <input type="checkbox"/> No:	
Loyalty Member of Nawaloka Hospital:- <input type="checkbox"/> Yes <input type="checkbox"/> No:	
If Patient is Insured:- <input type="checkbox"/> Yes <input type="checkbox"/> No:	
If You are Insured please state the Name of Insurances, company and provide details of insurance Policy:	
Name of Insurances Company :-----	
-----	
Details of Insurance Policy :-----	
-----	

FOR THE USE OF ALOHA-NAWALOKA REFERRAL CENTER MALDIVES ONLY.		
REMARKS:-----		
-----		
-----		
-----		
Voucher NO: .....		
Name:- -----	Signed:- -----	Date: -----