AXA ASSISTANCE
redefining / service

Your patient has requested our assistance in coordinating ongoing medical treatment while they are traveling outside of the US. To start the process we require the completion of this brief questionnaire. After review by our Medical team, we may be request additional information to share with the potential accepting physician in the destination country. We appreciate your assistance to ensure that your patient has continuity of care while abroad.

To be completed by patient:

Patient Name: _____

Doctor Name: _____

Date of Birth: _____

Diagnosis: _____

To be completed by treating physician:

Current Medication Information:

Name of Medication	Recommended dosage	Date of last administration	Date of next planned administration	Will you be prescribing for the duration of travel? (Y/N)	Medical reason for medication	List any Contraindications of continuing medication regimen while abroad	Acceptable alternate medication, if not available abroad

Past Medical History: _____

When was patient last seen in your office:_____

Recommended treatment plan while abroad (including specialist type and date of next appointment):
_____

Any additional information that would help our office coordinate continuation of treatment for your patient.
_____
_____

_____ _____

Physician Stamp / Signature Date