SKÅNE CARE
SWEDISH HEALTHCARE EXCELLENCE

Medical care inquiry

For Skåne Care to handle the inquiry efficiently and be able to offer the medical treatment requested this document should be filled in by a certified healthcare professional, preferably your treating physician.

Patient	
Family name:	First name:
Date of birth yyyy-mm-dd	Sex: ☐ Male ☐ Female
Marital status: ☐ Single ☐ Married ☐ Widow	Number of children (if any):
Citizenship:	Occupation:
Street:	Postal code:
City:	Country:
Phone:	E-mail:
Fax:	
Contact person (if other than patient)	
Family name:	First name:
Street:	Postal code:
City:	Country:
Phone:	E-mail:
Accompanying person to Sweden (if any)	
Family name:	First name:
Relation to the patient:	Spoken languages:
Street:	Postal code:
City:	Country:
Phone:	E-mail:
Fax:	

+46 768 870 590
INFO@SKANECARE.COM
SKÅNE CARE AB, TROLLEBERGSVÄGEN 5
SE-222 29 LUND, SWEDEN

Medical history

Diagnosis/chief complaint:

Medical problems:
- [ ] Hypertension (HTN)
- [ ] Chronic obstructive pulmonary disease (COPD)
- [ ] Coronary artery disease (CAD)
- [ ] Diabetes
- [ ] Thyroid problems, please specify:
- [ ] Psychological disorders, please specify:
- [ ] Others, please specify:
- [ ] Family history of medical problems, please specify:
- [ ] Abnormal laboratory/X-ray findings, please specify:

Drug/food allergy:
- [ ] No
- [ ] Yes, please specify:

Previous surgeries:
- [ ] No
- [ ] Yes, please specify:

The patient has been hospitalized during the last 6 months:
- [ ] No
- [ ] Yes

The patient is MRB positive:
- [ ] No
- [ ] Yes

Antibiotic therapy:
- [ ] No
- [ ] Yes, please specify reason, type, duration, start date and duration:

Consciousness:
- [ ] Normal
- [ ] Disoriented
- [ ] Comatose
- [ ] Aggressive
- [ ] Other, please specify:

Respiration:
- [ ] Normal
- [ ] Dyspnea
- [ ] Tracheostomy
- [ ] Assisting device, please specify:
- [ ] Other, please specify:

Cardiovascular:
- [ ] Normal
- [ ] Pacemaker
- [ ] Other, please specify:

Gastrointestinal:
- [ ] Normal
- [ ] Swallowing problems
- [ ] NG Feeding
- [ ] Incontinence
- [ ] Special diet, please specify:
- [ ] Other, please specify:

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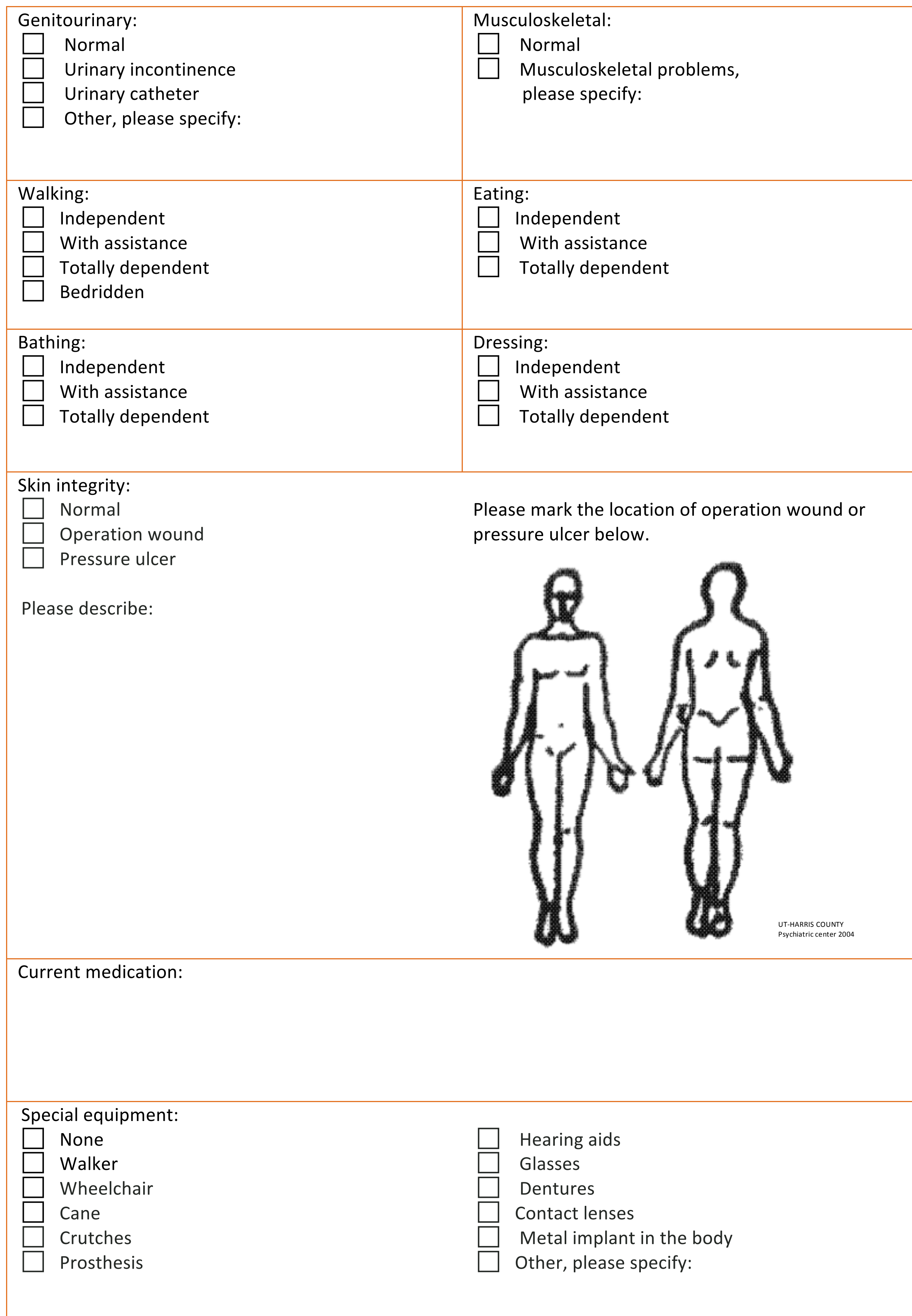

Genitourinary:

- ☐ Normal
- ☐ Urinary incontinence
- ☐ Urinary catheter
- ☐ Other, please specify:

Musculoskeletal:

- ☐ Normal
- ☐ Musculoskeletal problems, please specify:

Walking:

- ☐ Independent
- ☐ With assistance
- ☐ Totally dependent
- ☐ Bedridden

Eating:

- ☐ Independent
- ☐ With assistance
- ☐ Totally dependent

Bathing:

- ☐ Independent
- ☐ With assistance
- ☐ Totally dependent

Dressing:

- ☐ Independent
- ☐ With assistance
- ☐ Totally dependent

Skin integrity:

- ☐ Normal
- ☐ Operation wound
- ☐ Pressure ulcer

Please describe:

Please mark the location of operation wound or pressure ulcer below.

UT-HARRIS COUNTY
Psychiatric center 2004

Current medication:

Special equipment:

- ☐ None
- ☐ Walker
- ☐ Wheelchair
- ☐ Cane
- ☐ Crutches
- ☐ Prosthesis
- ☐ Hearing aids
- ☐ Glasses
- ☐ Dentures
- ☐ Contact lenses
- ☐ Metal implant in the body
- ☐ Other, please specify:

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Spoken languages:	Translation required: ☐ Yes ☐ No
Communication difficulties, please specify:	Accommodation (in home country): ☐ Home ☐ Hospital ☐ Other, please specify:
Patient in need of: ☐ Treatment ☐ Investigation ☐ Written second opinion ☐ Rehabilitation ☐ Other, please specify:	
Additional information relevant for medical care and stay in Sweden	

Send the completed application form together with:

- Consent for processing of personal and medical information.
- Copy of passport.
- Additional relevant information, documents or X-rays.

Please take into consideration the sensitivity of the personal and medical information that you send to us. Such documents can be received via encrypted data if possible or post sent to Skåne Care AB, Trollebergsvägen 5, 222 29 Lund, Sweden.

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