SWIXMED

Application For Medical Treatment In Switzerland

Complete as much of this form as you can and send it to us by mail, fax or e-mail.
We will contact you without delay.

PATIENT INFORMATION

Family name:
First name:
Street:
Postal code:
City:
Country:
Date of birth: Year Month Day
Gender: ☐ Male ☐ Female
Nationality:
Mother tongue: Other languages:

CONTACT DETAILS

Phone number:
Mobile number:
Fax number:
E-mail address:
Please write name and relationship to the patient if the contact person is not the patient:

Name of parent or guardian if patient is under 18 years old:
Best time to contact:
Best way to contact:

Desired MEDICAL SERVICES in Switzerland

Please give a brief description of your condition and treatment goal:

If available, please also send any medical reports or discharge summaries relevant to your application.

Terms of Use

I, the patient or their legal representative, authorize SWIXMED LTD and its employees to forward relevant personal data and medical information by mail, fax or e-mail to Swiss Healthcare Providers.

Signature of the patient or representative Date Place

Our CONTACT details are:

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applications@swixmed.com