

# ONLINE APPOINTMENT REQUEST

Been to MMM?

YES

NO

If yes: UHID NO:

Title:

Patient Name (As it appears on passport):

Last Name:

First Name:

Middle Name:

Date of Birth:

Gender:

Patient Address:

City:

State:

Postal Code:

Country:

Phone:

Email:

Appointment date requested: First choice (D/M/Y)      Second choice (D/M/Y)

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Your Medical Condition/Diagnosis:

Please share your investigations report of other hospitals with the name of the doctor you have been treating with:

Type of payment:

Self pay:

Cashless:

For Assistance Contact:

**Please note:**

For any queries contact-----

Please bring your original reports when you come to the hospital.

We will revert back once your appointment is confirmed.

We need to know your requirement:

YES

NO

Airport pickup

SIM card

Guest House:

Internet access in the room:

Transportation for shopping:

Transportation for sight seeing:

Airport drop:

## CHECKLIST

PATIENT NAME:

### **Before Admission:**

YES

NO

DATE/TIME

Received email fm pt:

Replied confirming the date:

Mail to overseas team?

### **On the day of admission:**

Pluck card:

Transportation:

Room blocked:

Room cleaned:

Nurses informed:

