WIENER PRIVATKLINIK ACADEMY
CENTRAL EUROPEAN CANCER CENTER

Pelikangasse 15
A-1090 Vienna

Telephon: +43 1 40180 - 8700
Telefax: +43 1 40180 - 7050

Mail: info@wpk.at

Dear Patient,

As you have requested an appointment, it is necessary to assess your status in order to give you the qualitatively best possible advice.
Please complete the attached form (please type or print clearly) and send it as one file via e-mail to info@wpk.at

Please note: Patients have to be in Vienna for evaluation and the definition of possible treatment options. We do not offer second opinions at a distance with the exception with the facilitation of a pathology review.

Thank you and best wishes,

The WPK Academy Central European Cancer Center Team

PATIENT INFORMATION

Today's Date	

Patient Name (last)	**Patient Name (first)**

Date of birth (D/M/Yr)		
Sex	☐ Male	☐ Female
City		
Country		
Email		
Phone		
Diagnosis		
Date of diagnosis		

Is this an original diagnosis or a recurrence?	☐ Original	☐ Recurrence	☐ Unknown
If this is a recurrence, what is the date of the original diagnosis?			
How was the disease diagnosed?	☐ Surgical Biopsy	☐ Fine Needle Aspiration	☐ Resection
Has the disease spread to other organs (Metastases)?	☐ Yes	☐ No	
If "Yes", please specify where			
and the date it was discovered			
Is / Was the patient a smoker?	☐ Yes	☐ No	
If "Yes", how many cigarettes per day			

Patient Status:

Is the patient ambulatory (walking, out of bed) more than 50% of the day?	☐ Yes	☐ No
Is the patient able to take care of self without assistance?	☐ Yes	☐ No
Does the patient require the use of oxygen?	☐ Yes	☐ No
Is the patient jaundiced (skin and/or eyes yellow)?	☐ Yes	☐ No
Does the patient have ascites (liquid abdominal cavity/swollen)?	☐ Yes	☐ No
Does the patient have difficulty eating?	☐ Yes	☐ No

Has the patient had surgery related to above-mentioned diagnosis?	☐ Yes	☐ No
If yes, please give surgery date		

Has the patient received Chemotherapy?	☐ Yes	☐ No
If yes, please list specific chemo agents and doses		
What is the date of the last treatment?		
When is the next treatment scheduled?		

Has the patient received Radiotherapy?	☐ Yes	☐ No
If Yes,to which part of the body?		
What is the date of the last treatment?		

Has patient suffered from heart problems?	☐ Yes	☐ No

When was the last	**Date**	**Area**
CT Scan		
MRI Scan		
PET-CT Scan		

What type of service are you requesting?	☐ get treated in Vienna *
*** these patients will be administered preferentially due to the urgency of our intervention.**	☐ start my treatment in Vienna, but continue at home *
	☐ second Opinion
	☐ other (please specify)

I, _____ hereby empower the Wiener Privatklink Betriebs-Ges.m.b.H. & Co. KG. Pelikangasse 15, 1090 Wien that they are allowed to act in my name for forwarding medical information (e.g. medical history, reports, laboratory results, etc.) to my preferred doctor or a doctor recommended by Wiener Privatklinik for the above mentioned requested services.

Date:_____ Signature:_____