

International Healthcare Services

University of Nebraska Medical Center / The Nebraska Medical Center

Thank you for contacting International Healthcare Services. We value your trust to consider our Telemedicine Second Opinion (TSO) program. We realize in a highly competitive global healthcare market you have choices and we hope to extend a warm welcome and easy process to facilitate your medical opinion.

The purpose of the individualized Telemedicine Second Opinion (TSO) program of International Healthcare Services at The Nebraska Medical Center and The University of Nebraska Medical Center ("UNMC") is to provide remote medical consultation services to the patients through their treating doctor or the request could be made directly by the treating doctor.

The attached CONSENT FORM FOR TELEMEDICINE SECOND OPINION is hereby made part of the TSO request.

UNMC's TSO services provide a remote tele-health consultation. The TSO may in some special cases, be the first step to facilitate a patient referral to UNMC. Please contact our office for further information about patient referral to UNMC. To begin the TSO process, please complete the following steps:

1. Complete the TSO packet. Includes: CONSENT FORM FOR TELEMEDICINE SECOND OPINION, Patient Information sheet and Credit Card Authorization Form.
2. Send the most recent typed **medical records** in English.
3. If **Radiology** images and corresponding reports related to the clinical specialty have to be reviewed, you must send us necessary images (CD's or films).
4. If **Pathology** blocks and stains are requested for review for diagnosis and/or genetic consult, additional cost applies. You must send us necessary blocks or stains by a courier service. In order to avoid a delay in shipping international, please include a letter with the pathology block/stain and on the commercial invoice indicating:

"Slides and/or paraffin blocks and corresponding pathology reports are of non-infectious and non-contagious human tissue taken from the _____ (tissue/organ) which are fixed and/or preserved in paraffin. This specimen has never been cultured. It is for medical review by the Department of Pathology at the University of Nebraska Medical Center in Omaha, Nebraska and requires expedited delivery. The value is US \$1.00".

5. Forward the completed TSO packet and medical information via facsimile or international courier to:

International Healthcare Services
The Nebraska Medical Center
988130 Nebraska Medical Center
Omaha, NE 68198-8130
Phone: (402) 559-3090 / Fax: (402) 552-2405
Email: oihs@nebraskamed.com

To avoid delays in processing your TSO, please review all the corresponding medical information and billing method provided. We suggest the documents be reviewed for accuracy, completeness and the most up-to-date information made available. All documents must be in English. If translation is not possible please contact International Healthcare Services Patient Relations for assistance at (402) 559-3090.

Next Steps When TSO Tele-Health Request is received:

1. International Healthcare Services has a specialized triage nurse to facilitate the entire Tele-health request. The information is reviewed in English. The medical information is reviewed for completeness and is prepared for and sent to the specialized doctor for the disease.
2. International Healthcare Services' billing office reviews the payment method. The TSO process will not begin until pre-payment is received and posted to the account specifically for the Consult.
3. Regular updates are provided on the progress of the TSO request. Please note a representative can be contacted at (402) 559-3090 Monday-Friday (7:30am-3:30pm CST). Throughout the year, United States holidays apply and may delay consults if requested during the holidays.

Excellence in Cancer Care and Transplantation

4. Time is of the essence and we recognize the urgency in the serious medical conditions patients face. Generally, the TSO will be responded to within 72 - 96 hours of the time of receipt of ALL information, but may be longer in some cases. If there are prolonged delays, we will update the requestor. In most cases, additional time is required for reviewing pathology or genetic testing.
5. If we receive additional medical records and/or questions after the doctor has started the review, additional costs may apply. If the doctor requests additional information, as a result of incomplete initial medical information received and if a case requires further review at a later date, there will be additional consult charges.
6. No medical information provided by the patients or doctors will be returned upon completion of the TSO, unless requested by the patient or doctor. In which case, an additional processing fee of US \$50 for shipping and handling will be charged. After one year of inactivity, medical records may be appropriately discarded.
7. The cost of this service is determined by the complexity of the case. Please request our price list for additional information. The minimum cost ranges from US\$390. A more accurate estimate can be provided upon request.

Upon completion of the TSO, the patient's case will be closed. If the patient would like to schedule an appointment on-site at University of Nebraska Medical Center, the case will be forwarded to International Healthcare Services Patient Relations Office, which can assist with the patient referral.

We look forward to serving your healthcare needs and facilitating the world-renowned expertise provided at The Nebraska Medical Center and The University of Nebraska Medical Center.



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TELE-HEALTH CONSULTATION REQUEST FORM

Date: _____
To: **International Healthcare Services**
From: **Patient / Physician** (*please circle one*)

PHYSICIAN INFORMATION

Date: _____
Physician Name: _____
Address: _____

Phone: _____ Mobile: _____
Fax: _____ Email: _____

PATIENT INFORMATION

Date: _____
Patient's Name: _____
Father's Name: _____
Mother's Name: _____
Address: _____

Phone: _____ Mobile: _____
Fax: _____ Email: _____
Birth Date: ____ / ____ / ____ (MM/DD/YYYY) Gender: Male / Female (*please circle one*)

PATIENT DIAGNOSIS

INFORMATION SENT

Latest Medical Report:	Yes / No (<i>please circle one</i>)
Present Conditions Report:	Yes / No (<i>please circle one</i>)
Discharge Summary Report:	Yes / No (<i>please circle one</i>)
Laboratory Reports:	Yes / No (<i>please circle one</i>)
Radiology Images and Reports (x-rays, MRI, CT, etc):	Yes / No (<i>please circle one</i>)
Numbered Pathology Slides and Reports:	Yes / No (<i>please circle one</i>)
Biopsy Block and Reports:	Yes / No (<i>please circle one</i>)
Other Information:	Yes / No (<i>please circle one</i>)

QUESTIONS/COMMENTS FOR UNMC PHYSICIANS AND PATIENT'S CONDITION

WILL YOU NEED ASSISTANCE WITH THE FOLLOWING?

- Interpreter Services? Yes / No *(please circle one)*
Languages you speak: _____
- Hospital Accommodations? Private Room / Semi-Private Room (2 beds) *(please circle one)*
- Hotel Accommodations? Yes / No *(please circle one)*
- Number of guest traveling with patient? _____
- Number of rooms needed? _____
Smoking / Non-Smoking room *(please circle one)*
- Transportation from Omaha Airport (OMA) to hotel or hospital? Yes / No *(please circle one)*
- Special diet during your hospital stay? Yes / No *(please circle one)*
If yes, please specify diet: _____

FINANCE & BILLING

Please check one:

- For self-pay patients requiring hospitalization, payment in advance is required.
- For Embassy cases, prior Embassy arrangements must be made in advance.



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PT NAME _____
MR # _____

1. **Patient Name:** _____ **Birth date:** _____
Address: _____ **Telephone:** _____
_____ **SSN#:** _____

2. I hereby authorize and request release of my medical records:

FROM: _____
(Health care facility to send information)
TO: _____
(Name of institution or individual to receive information)

(Street Address)

(City) (State) (Zip)

3. Information to be disclosed:

From (date) _____ **to (date)** _____

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> EKG/EEG Reports
<input type="checkbox"/> History and Physical Examination	<input type="checkbox"/> Emergency Room Record
<input type="checkbox"/> Operative Report	<input type="checkbox"/> Clinic Notes
<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Psychiatric Information
<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Physical/Occupational Therapy Notes
<input type="checkbox"/> X ray Reports	<input type="checkbox"/> Prenatal (Pregnancy) Records
<input type="checkbox"/> Other (Please specify) _____	

4. Purpose of release: Medical care Personal records Attorney
 Other _____

5. This statement of consent can be revoked at any time before disclosure of the information, and expires, in any event, six months after it is signed. Date ___/___/___ of expiration.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I revoke the authorization, it will not have any effect on actions taken prior to receipt of the revocation.

I understand that the individual/institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be redisclosed publicly and no longer be protected by those regulations.

(Signature of patient)

(Date)

(Signature of parent, guardian, or
authorized representative)

(Relationship of above person to patient)



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CREDIT CARD & PAYMENT AUTHORIZATION

I authorize UNMC to charge the following credit card for the cost of Telemedicine Second Opinion of up to \$1,000. I understand and agree that the charges will be posted to the credit card upon receipt of this authorization. Pathology second opinion may require additional testing to provide a definitive diagnosis this may add additional charges. You will be contacted in advance and prior to conducting any additional test.

This information will be held confidential as provided by the Health Information Privacy and Portability Act (HIPAA).

CREDIT CARDHOLDER INFORMATION

Check Money Order Credit Card Wire Transfer (Check one)

Cardholder's Name: _____

Cardholder's Signature: _____

Billing Address: _____

Street Address and/or P.O. Box

City, Province, Country & Postal Code

Phone: _____ **Fax:** _____

Please include Country Code & City Code, if outside the US.

Credit Cards Accepted: Visa Master Card Discover American Express (Check one)

Card Number: _____ **Expiration Date:** _____

MM/YYYY

V Code (Last 3 or 4 digits on back card): _____ **Payment amount to be charged:** \$ _____ . _____ **USD**

For The Nebraska Medical Center/UNMC office use only:

Authorization #: _____ **Date:** _____