MEDIF

STANDARD MEDICAL INFORMATION FORM FOR AIR TRAVEL

PART 1
To be completed by SALES OFFICE / AGENT

Answer ALL questions – Put a cross (x) in the "YES" or "NO" boxes

Use BLOCK LETTERS or TYPEWRITER when completing this form.

A NAME / INITIALS / TITLE

B PROPOSED ITINERARY – (Airline(s), flight number(s), class(es), date(s), segment(s), reservation status)

Transfer from one flight to another often requires LONGER connecting time.

C NATURE OF Disability — MEDICAL CLEARANCE REQUIRED? Yes ☐ No ☐

D IS STRETCHER NEEDED ON BOARD? (All stretcher cases must be escorted). Yes ☐ No ☐

Request rate if unknown

E INTENDED ESCORT (Name, sex, age, professional qualification, segments if different from passenger). If untrained, state "TRAVEL COMPANION".

For the Blind and / or Deaf, state if escorted by a trained dog.

F WHEELCHAIR NEEDED? No ☐ Yes ☐

Categories are: WCHR WCHS WCHC

Wheelchair Category:

Own Wheelchair?	Collapsible?	Power Driven?	Battery Type (spillable)?
No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐

Wheelchairs with spillable batteries are "dangerous goods" and are permitted on passenger aircraft only under certain conditions, which can be obtained from the airline(s). In addition, certain countries may impose specific restrictions.

G AMBULANCE NEEDED? No ☐ Yes ☐ → To be arranged by AIRLINE — No ☐ specify Ambul. Company contact; Yes ☐ specify destination address

H OTHER GROUND ARRANGEMENTS NEEDED? No ☐ Yes ☐

If Yes, SPECIFY below and indicate for each item (a) the ARRANGING airline or other organisation, (b) a+ whose EXPENSE, and (c) CONTACT addresses / phones where appropriate or whenever specific persons are designated to meet / assist the passenger.

1	Arrangements for delivery at airport of DEPARTURE.	No ☐	Yes ☐	Specify:	
2	Arrangements for assistance at CONNECTING POINTS.	No ☐	Yes ☐	Specify:	
3	Arrangements for meeting at airport of ARRIVAL.	No ☐	Yes ☐	Specify:	
4	Other requirements or relevant informations.	No ☐	Yes ☐	Specify:	

K SPECIAL IN-FLIGHT ARRANGEMENTS NEEDED such as special meals, special seating, leg-rest, extra eat(s), special equipment, etc. No ☐ Yes ☐

If Yes, DESCRIBE and indicate for each item; (a) SEGMENT(S) on which required, (b) airline ARRANGED or arranging third party, and (c) at whose expense. Provision of SPECCIAL EQUIPMENT such as oxygen etc., always requires completion of Part 2 overleaf.

(See Note * at the end of PART 2 overleaf)

L DOES PASSENGER HOLD A "FREQUENT PASSENGER'S MEDICAL CARD" VALID FOR THIS TRIP? (FREMEC) No ☐ Yes ☐

If Yes, add below FREMEC data to your reservation request. If No, (or if additional data needed by carrying airline(s), have physician in attendance complete PART 2 hereof.

FREMEC					
(FREMEC Number)	(Issued by)	(Valid until)	(Sex)	(Age)	(Incapacitation))

(Incapacit. cont.) (Limitations)

PASSENGER'S DECLARATION:

I hereby authorize: _____ (Name of nominated Physician) to provide the airlines with the information required by those airline's medical departments for the purpose of determining my fitness for carriage by air and in consideration thereof I hereby relieve that physician of his / her professional duty of confidentiality in respect of such information, and agree to meet such fees in connection herewith.

I take note that, if accepted for carriage, my journey will be subject to the general conditions of carriage / tariffs of the carrier(s) concerned and that the carrier(s) do not assume any special liability exceeding those conditions / tariffs.

I am prepared, at my own risk, to bear any consequences which carriage by air may have for my state of health and I release the carrier, its employees, servants and agents from any liability for such consequences.

I agree to reimburse the carrier(s) upon demand for any special expenditures or costs in connection with my carriage.

(Where needed, to be read by / to the passenger, dated and signed by him / her, of his / her behalf).

Place:	Date:	Passenger's Signature:

MEDIF

MEDICAL INFORMATION SHEET

(for official use only)

PART 2

To be completed
by
ATTENDING PHYSICIAN

The form is intended to provide CONFIDENTIAL information to enable the airlines' MEDICAL Department to assess the fitness of the passenger to travel as indicated in PART 1 hereof. If the passenger is acceptable, this information will permit the issuance of the necessary directives designed to provide for the passenger's welfare and comfort.

The PHYSICIAN ATTENDING the disabled passenger is requested to Answer All Questions. (Enter a cross "X" in the appropriate "Yes" on "No" boxes, and / or give precise, concise answers).

Use BLOCK LETTERS or TYPEWRITER when completing this form.

The form must be returned to:

(Carrier's Designated Office)

Airline's ref. Code

MEDA01	PATIENT'S NAME, INITIAL(S), SEX, AGE, WEIGHT, HEIGHT	
MEDA02	ATTENDING PHYSICIAN – Name & Address – Telephone Contact	Business: / Mobile (Preferred): / E-mail: / Home
MEDA03	MEDICAL DATA DIAGNOSIS in details (including vital signs) Day / Month / Year of the first symptoms	Current Symptoms Specify _____ Date of diagnosis:
		Bladder and bowel control Yes ☐ No ☐ Is the diagnosis indicated in Part (3) Yes ☐ No ☐ **If Yes, you must fill in the required information**
MEDA04	PROGNOSIS for the trip	Good ☐ Satisfied ☐ Poor ☐
MEDA05	Contagious AND communicable disease?	No ☐ Yes ☐ Specify:
MEDA06	Is patient in any way OFFENSIVE to other passengers? (Smell, appearance, conduct).	No ☐ Yes ☐ Specify:
MEDA07	Can patient use a normal aircraft seat with seatback placed in the UPRIGHT position when so required? ☐ Can patient use a business/first class if recline to 180 degrees all the time? ☐ Can patient use a business class seat if recline less than 180 degrees and upright position during takeoff and landing? ☐ patient need stretcher? ☐	
MEDA08	Can patient take care of his own needs on board UNASSISTED * (including meals, visit to toilets, etc.)?	Yes ☐ No ☐ If not, type of help needed;
MEDA09	If to be ESCORTED, is the arrangement proposed in PART 1 / E hereof satisfactory for you?	Yes ☐ No ☐ If not, type of escort proposed to YOU:
MEDA10	Does patient need OXYGEN ** equipment in flight? (If Yes, state rate of flow).	No ☐ Yes ☐ Litres per Minute ☐ Continuous Yes ☐ No ☐ Would he be affected by relative hypoxia (25 - 30%) drop of oxygen? Yes ☐ No ☐
MEDA11	Does patient need any MEDICATION, respirator incubator, etc. **)?	(a) on the GROUND while at the airport(s): No ☐ Yes ☐ Specify:
MEDA12		(b) on board of the AIRCRAFT: No ☐ Yes ☐ Specify:
MEDA13	Does patient need HOSPITALIZATION? (If Yes, indicate arrangement made or, if none were made, indicate "NO ACTION TAKEN).	(a) during long layover or nightstop at CONNECTING POINTS en route No ☐ Yes ☐ Action:
MEDA14		(b) upon arrival at DESTINATION: No ☐ Yes ☐ Action:
MEDA15	Other remarks of information in the interest of your patient's smooth and comfortable transportation.	None ☐ Specify, if any **
MEDA16	Other arrangements made by the attending physician.	**Specify if passenger is fit for travel:** Yes ☐ No ☐

NOTE (*) Cabin attendants are NOT authorised to give special assistance to particular passengers to the detriment of their service to other passengers. – Additionally, they are trained only in FIRST AID and to provide assistance to the attendants to operate the oxygen bottle and they are NOT PERMITTED to administer any injection or to give any medication.

IMPORTANT FEES IF ANY, RELEVANT TO THE PROVISION OF THE ABOVE INFORMATION AND FOR CARRIER - PROVIDED SPECIAL EQUIPMENT (**) ARE TO BE PAID BY THE PASSENGER CONCERNED.

Place:	Valid for:			Date:	Attending Physician's Signature:
	10 days	30 days	90 days		

PART 3

To be completed
by
ATTENDING PHYSICIAN

MEDIF

MEDICAL INFORMATION SHEET

(for official use only)

The form is intended to provide CONFIDENTIAL information to enable the airlines' MEDICAL Department to assess the fitness of the passenger to travel as indicated in PART 1 hereof. If the passenger is acceptable, this information will permit the issuance of the necessary directives designed to provide for the passenger's welfare and comfort.

The PHYSICIAN ATTENDING the disabled passenger is requested to Answer All Questions. (Enter a cross "X" in the appropriate "Yes" on "No" boxes, and / or give precise, concise answers).

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The form must be returned to:

(Carrier's Designated Office)

ADDITIONAL CLINICAL INFORMATIONS

ANAEMIAS AND CARDIAC CONDITIONS

Yes ☐ No ☐ **IF YES, FILL OUT ITEMS BELOW**

1. **Anaemia** ☐ YES ☐ NO — If Yes, give the recent result in grams of Hemoglobin. _____
2. **Angina** ☐ YES ☐ NO — When was last episode? _____
   - Is the condition stable? ☐ YES ☐ NO
   - Functional class of the patient? ☐ No symptoms ☐ Angina with important efforts ☐ Angina with light efforts ☐ Angina at rest
   - Can the patient walk 100 metres at a normal pace or climb 10 - 12 stairs without symptoms? ☐ YES ☐ NO
3. **Myocardial infarction** ☐ YES ☐ NO — Date _____
   - Complications ☐ YES ☐ NO — If YES, give details _____
   - Stress EKG done? ☐ YES ☐ NO — If YES, what was the result? _____ Metz _____
   - If angioplasty or coronary bypass, can the patient walk 100 metres at normal pace or climb 10 - 12 stairs without symptoms? YES NO
4. **Cardiac failure** ☐ YES ☐ NO — When was the last episode? _____
   - Is the patient controlled with medication? ☐ YES ☐ NO
   - Functional class of the patient? ☐ No symptoms ☐ Shortness of breath with important efforts ☐ Shortness of breath with light efforts ☐ Shortness of breath at rest
5. **Syncope** ☐ YES ☐ NO — Last episode _____
   - Investigations? ☐ YES ☐ NO — If YES, state results _____

RESPIRATORY CONDITION

Yes ☐ No ☐ **IF YES, FILL OUT ITEMS BELOW**

- Has the patient had recent blood gasses? YES ☐ NO ☐
- Blood gasses were taken on: ☐ Room air ☐ Oxygen ☐ Others

  If YES, what were the results _____ pCO_2 _____ pO_2 _____

  Saturation _____ Date of exam _____
- Does the patient retain CO_2? ☐ YES ☐ NO
- Has his/her condition deteriorated recently? ☐ YES ☐ NO
- Can the patient walk 100 metres at a normal pace or climb 10 - 12 stairs without symptoms? ☐ YES ☐ NO
- Has the patient ever taken a commercial aircraft in these same conditions? ☐ YES ☐ NO
  - If YES, when? _____
  - Did the patient have any problems? _____

PSYCHIATRIC AND NEUROLOGICAL CONDITIONS

Yes ☐ No ☐ **IF YES, FILL OUT ITEMS BELOW**

1. **Psychiatric Condition**
   - Is there a possibility that the patient will become agitated during flight? Yes ☐ No ☐
   - Has he/she taken a commercial aircraft before? Yes ☐ No ☐ If Yes, date of travel _____
2. **Seizure Disorder**
   - What type of seizures? _____
   - Frequency of the seizures? _____
   - When were the last seizures? _____
   - Are the seizures controlled by medication? _____

OTHER ARRANGEMENTS MADE BY THE ATTENDING PHYSICIAN

Specify if passenger is fit for travel: Yes ☐ No ☐

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IMPORTANT FEES IF ANY, RELEVANT TO THE PROVISION OF THE ABOVE INFORMATION AND FOR CARRIER - PROVIDED SPECIAL EQUIPMENT (**) ARE TO BE PAID BY THE PASSENGER CONCERNED.

Place:	Valid until:	Date:	Attending Physician's Signature: