

TO BE COMPLETED BY THE PASSENGER (PLEASE PRINT IN BLCK CAPITAL LETTERS)

Doctors/Office use only

1. Family name: _____ Given name: _____ Title: _____ Age: _____

2. Address: _____ Telephone contact no.: _____

3. Proposed Itinerary: Flt. No: _____ Date: _____ From: _____ To: _____

4. Whats is the **nature** and **duration** of your illness/injury? _____

5. If you are being escorted, please provide details of your escort:

Name: _____ Title: _____ Age: _____ Qualifications: _____

6. Do you require a wheelchair? For long distances
To aircraft door to
Aircraft seat

7. Would you prefer: Aisle seat
Seat near toilet

8. Do you need an ambulance Yes No

*All ambulances have to be arranged by the treating doctor/hospital/evacuation company.
Clearance CANNOT be given until bookings are confirmed.*

9. Have ambulance transfers been confirmed Departure port
in: Transit port
Arrival port

10. Do you have a life-threatening allergy to any food types?
Please specify _____

11. Do you need to use electrical equipment powered by the aircraft supplies? Yes No
Please specify _____

OFFICE USE ONLY

Ref. No. _____

Information Complete

Clearance not required

Type of assistance required

Ground

Wheel chair

Stretcher

Escort

Oxygen required

2L/m

4L/m

Continuous

Intermittent

No. of cylinders need

Medical equipment required

Equipment approved

Approved for uplift

Dr's sig. _____

Date _____

Time _____

Approved for uplift

Reservation _____

Date _____

Time _____

PASSENGER'S DECLARATION

I HEREBY AUTHORISE _____
(Name of treating doctor)

To provide the airlines with the information required by those airlines medical departments for the purpose of determining my fitness for carriage by air and in consideration therefore I hereby relieve the physician of his/her professional duty of confidentiality in respect of such information, and agree to meet such physician's fee in connection therewith.

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, service agents and doctors from any such liability for such consequence.

PASSENGER'S SIGNATURE _____ Date _____ Place _____

TO BE COMPLETED BY YOUR DOCTOR (PLEASE PRINT IN BLOCK CAPITAL LETTERS)

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1. Patient's Family Name _____ First name _____ Date of birth _____ Sex _____

2. Treating physician 's name and address _____

Telephone contact: Business _____ A/H (Mobile) _____

3. Medical diagnosis (in detail) _____

Date of first symptoms _____ Date of diagnosis _____ Date of Surgery _____

Anemia	Nil	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Blood pressure
Dyspnoea	Nil	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	
Pain	Nil	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	

4. Prognosis for the journey? Poor Fair Good Excellent

5. Any contagious or communicable disease? Yes No

6. Has passenger control of:
 Bowel Yes No
 Bladder Yes No

7. Is your patient's condition (physical or mental) likely to cause distress or discomfort to other passengers? Yes No

8. Has your patient:
 Had suicidal tendencies Yes No
 Been violent or required restraint Yes No
 Become noisy or agitated Yes No

9. Is your patient pregnant? Yes No Expected date of confinement _____
 Are there any pregnancy related problems? Yes No Details _____

10. Can your patient sit for the proposed journey with the seat fully upright? Yes No
If no then the patient will need a stretcher at an additional cost to the patient

11. Can your patient
 Walk to and board the aircraft Yes No
 Walk to the toilet unassisted Yes No
 Use the toilet unassisted Yes No
 Feed himself/herself unassisted Yes No

Flight attendants are unable to give special assistance with toileting and feeding

12. Does your patient need any treatment during the journey Yes No Details _____

13. Does your patient need to be accompanied? Yes No
 Is a medically trained escort necessary? Yes No

14. Will oxygen be required during the journey? Yes No L/m Continuous Intermittent

15. Is medical equipment to be used in flight? Yes No Please List _____

16. Having read the guiding principles, you are of the opinion that this patient is medically FIT/UNFIT to undertake the contemplated journey by air without causing any inconvenience or embarrassment to other passengers.

DOCTOR'S SIGNATURE _____ Date _____ Place _____