



INFORMATION SHEET FOR PASSENGERS REQUIRING MEDICAL ASSISTANCE (MEDIF)

(Kindly answer all questions in block letters, as necessary and put a cross (X) in 'NO' 'YES' boxes)

PART A.

To be completed by passenger (or representative)

A	Passenger Name		Sex	Age
			DOB	
	Contact email		Tel Nbr	
B	Intended Itinerary			
	From	To	Flight Nbr	Date
C	Nature of Incapacitation			
D	Escort for the Journey Required			
	<input type="checkbox"/> NO	<input type="checkbox"/> YES, by physician/nurse (name, tel.)	<input type="checkbox"/> YES, by companion (name, tel.)	
E	Assistance Required			
	<input type="checkbox"/> WCHR	Handicapped in walking. Needs assistance in terminal to/from gate, needs wheelchair or similar when passengers are boarded/deplaned. Does not need assistance in ramp bus, on passenger steps and in the aircraft cabin to/from seat, toilets and with meals.		
<input type="checkbox"/> WCHS	More severely handicapped in walking. Cannot use a ramp bus and needs assistance in boarding/deplaning (e.g. on passenger steps). Does not need assistance in the aircraft cabin to/from seat, toilets and with meals.			
<input type="checkbox"/> WCHS/OWN	As above - accompanied by own wheelchair. Add BD if battery-drive			
<input type="checkbox"/> WCHC	Non-ambulant, needs assistance in the aircraft to/from seat, toilets and possibly with meals.			
<input type="checkbox"/> WCHC/OWN	As above - accompanied by own wheelchair. Add BD if battery-driven wheelchair.			
F	Special In-Flight/Ground Arrangements			
	Specify Inflight Arrangements needed		Other ground and/or in-flight arrangements needed	
	<input type="checkbox"/> Special meal	<input type="checkbox"/> Oxygen occasional	Specify _____	
	<input type="checkbox"/> Special Seating	<input type="checkbox"/> Oxygen continuous		
G	Medical Equipment			
	Are you carrying any medical equipment into the cabin?		<input type="checkbox"/> NO	<input type="checkbox"/> YES
If yes, do you need to use during your flight?		<input type="checkbox"/> NO	<input type="checkbox"/> YES	
Please specify type of equipment (make/model) e.g CPAP, ventilator, nebuliser, portable oxygen concentrator, etc. Equipment must be battery powered for continuous use inflight		_____		
Equipment must be battery powered for continuous use in flight		_____		
Is the equipment battery powered? <input type="checkbox"/> YES <input type="checkbox"/> NO		Battery Type _____ <i>(include watt-hour rating)</i>		
Can the equipment be switched off during take-off/landing		<input type="checkbox"/> NO	<input type="checkbox"/> YES	
Do you have sufficient batteries for duration of flight <i>(in-seat power cannot be guaranteed)</i>		<input type="checkbox"/> NO	<input type="checkbox"/> YES	
H	Ambulance Transfers Required			
	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Name and address, telephone of hospital		
I	Hospitalisation			
	Have you been admitted to hospital within last four weeks? <input type="checkbox"/> NO <input type="checkbox"/> YES Date of admission: _____			
Date of discharge: _____ Reason for admission: _____				
Is hospitalisation required upon arrival? NO <input type="checkbox"/> YES <input type="checkbox"/>				
If yes, please specify name of hospital and contact				
<p><i>I herewith relieve the physician, who shall provide information on my medical condition, of his/her professional discretion and permit him/her to disclose to TUS Air such details on the condition of my health as may be required by the TUS Medical Advisors to judge upon my medical fitness to travel by air. I the undersigned will indemnify and release TUS Air, their representatives, and agents from all claims for damage sustained in connection with deterioration of my illness as a result of the transportation by air. In the case of a legal dispute the undersigned will have to prove that any such damage incurred by TUS Air or third parties through the transportation. I acknowledge that airline staff are not medically trained, and that the airline cannot guarantee that I will receive appropriate medical attention in any situation. I acknowledge that TUS Air reserves the right to refuse travel, notwithstanding completion of this form, if the airline considers that it is not in my best interest to fly. I declare that the information contained on this Part A and Part B (where applicable) is complete and accurate. I authorise TUS Air to use and release this information as required in the event of an emergency.</i></p>				
Date	Issuing Office		Signature of Passenger	

MEDICAL INFORMATION SHEET

The details requested below will be treated in strict confidence and will only be used to enable the medical advisors of TUS Air, as is their obligation, to judge by their air medical knowledge and experience if and under what conditions the patient can be permitted to travel by aircraft as requested. These details will also help the medical advisors in issuing appropriate instructions for the patient's care duly considering his/her diagnosis and the special circumstances of the requested air journey.

PART B

To be completed by
the attending
physician

(Kindly answer all questions in block letters, as necessary and put a cross (X) in 'NO' 'YES' boxes)

MEDA 01	Patient's name	Sex	DOB
MEDA 02	Name, address of attending physician	Tel.	
		Email	
MEDA 03	Diagnosis <i>(details including vital signs)</i>		
	Current symptoms and severity		
	Date of first symptoms	Date of diagnosis	Date of surgery
MEDA 04	Is patient's condition <input type="checkbox"/> Resolved <input type="checkbox"/> Stable and controlled		
	Following surgery <input type="checkbox"/> Uncomplicated recovery <input type="checkbox"/> Hb level (fractured hip/pelvis)		
MEDA 05	Prognosis for the flight <i>(e.g good/fair/poor)</i>		
MEDA 06	Contagious and communicable disease? <i>(specify)</i> <input type="checkbox"/> NO <input type="checkbox"/> YES		
MEDA 07	Can the patient use normal aircraft seat with seatback placed in the upright position? <input type="checkbox"/> NO <input type="checkbox"/> YES		
	Can the patient bend leg at the knee <input type="checkbox"/> NO <input type="checkbox"/> YES		
MEDA 08	Can patient take care of his own needs on board unassisted <input type="checkbox"/> NO <input type="checkbox"/> YES <i>(including meals, visit to toilet, etc)</i>		
	If not, state type of help needed		
MEDA 09	Shall passenger be escorted? <input type="checkbox"/> NO <input type="checkbox"/> YES		
	If yes, state type of escort proposed by you.		
MEDA 10	Does patient need oxygen during flight? <input type="checkbox"/> NO <input type="checkbox"/> YES		
	<input type="checkbox"/> continuous	<input type="checkbox"/> occasional	Rate of flow: <input type="checkbox"/> 2L/min <input type="checkbox"/> 4L/min
	<i>(passengers must supply own battery powered equipment with approved specifications to be inspected by TUS Air before flight)</i>		
	<u>TUS Air do not provide airport oxygen. If oxygen is needed whilst transiting through the airport, patients must make their own arrangements.</u>		
	Is ground oxygen required? <input type="checkbox"/> NO <input type="checkbox"/> YES		
	If yes, what arrangements has patient made to provide POC?		
MEDA 11	Does the patient need any medication, other than self-administered, and/or the use of special apparatus? <i>(specify)</i>		
	On the ground while at the airport <input type="checkbox"/> NO <input type="checkbox"/> YES		
	On board the aircraft <input type="checkbox"/> NO <input type="checkbox"/> YES		
MEDA 13	Does patient need hospitalisation? <i>(If yes indicate arrangements made)</i>		
MEDA 14	Other arrangements made by the attending physician		
Date	Place	Signature and stamp of attending physician	

Space for official use of TUS Air

Medical advice of TUS Medical Advisor

Date & Time of Reply

by Telephone

by Fax

by E - mail