

MEDICAL INFORMATION SHEET - (MEDIF)

(for official use only)

To be completed by ATTENDING PHYSICIAN

This form is intended to provide CONFIDENTIAL information to enable the airlines' MEDICAL Departments to assess the fitness of the passenger to travel. 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 incapacitated passenger is requested to ANSWER ALL QUESTIONS. Enter a cross "x" in the appropriate "yes" or "no" boxes, and/or give precise concise answers. COMPLETING OF THE FORM IN BLOCK LETTERS OR BY TYPEWRITER WILL BE APPRECIATED.

The form must be returned to:

(Carrier's Designated Office)

Airlines' Ref. Code MEDA 01	PATIENT'S NAME, INITIAL(S), SEX, AGE:		
MEDA 02	ATTENDING PHYSICIAN Name & Address Telephone Contact	Business:	Home:
MEDA 03	MEDICAL DATA: DIAGNOSIS in details (including vital signs) Day/month/year of first symptoms:	Date of operation	Date of diagnosis
MEDA 04	Prognosis for the flight(s):		
MEDA 05	Contagious AND communicable disease?	Yes ___ No ___	Specify:
MEDA 06	Would the physical and/or mental condition of the patient be likely to cause distress or discomfort to other passengers?	Yes ___ No ___	Specify:
MEDA 07	Can patient use normal aircraft seat with seatback placed in the UPRIGHT position when so required?	Yes ___ No ___	
MEDA 08	Can patient take care of his own needs on board UNASSISTED* (including meals, visit to toilet, etc.)?	Yes ___ No ___	If not, type of help needed:
MEDA 09	If to be ESCORTED, is the arrangement satisfactory to you?	Yes ___ No ___	If not, type of escort proposed by YOU:
MEDA 010	Does patient need OXYGEN**equipment in flight? (If yes, state rate of flow)	Yes ___ No ___	_____ Litres per Minute No ___ Yes ___ Continuous?
MEDA 011	Does patient need any MEDICATION* other than self-administered, and/or the use of special apparatus such as respirator, incubator, etc.**?	(a) on the GROUND while at the airport(s): Yes ___ No ___	Specify:
MEDA 012		(b) on board of the AIRCRAFT: Yes ___ No ___	Specify:
MEDA 013	Does patient need HOSPITALISATION? (If yes, indicate arrangements made or, if none were made, indicate "NO ACTION TAKEN")	(a) during long layover or nightstop at CONNECTING POINTS en route: Yes ___ No ___	Action:
MEDA 014		(b) upon arrival at DESTINATION: Yes ___ No ___	Action:
MEDA 015	Other remarks or information in the interest of your patient's smooth and comfortable transportation:	None ___	Specify if any**:
MEDA 016	Other arrangements made by attending physician:		

NOTE (*) Cabin attendants are NOT authorized to give special assistance (e.g. lifting) to particular passengers, to the detriment of their service to other passengers. Additionally, they are trained only in FIRST AID and are NOT PERMITTED to administer any injection, or to give medication.

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

Date:	Place:	Attending Physician's Signature: STAMP OF MEDICAL INSTITUTION
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PASSENGER'S DECLARATION
"I HEREBY AUTHORISE _____
(Name of nominated physician)

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 thereof I hereby relive that physician of his/her professional duty of confidentiality in respect of such information, and agree to meet such physician's fees in connection therewith.
I take note that, if accepted for carriage, my journey will be subject to the general condition of carriage/tariffs of the carrier concerned and that the carrier does not assume any special liability exceeding those conditions/tariffs.
I agree to reimburse the carrier upon demand for any special expenditures or costs in connection with my carriage.*
(Where needed, to be read by/to passenger, dated and signed by him/her or on his/her behalf).

Date:	Place:	Passenger's Signature:
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**To be completed by
SALES OFFICE/AGENT**

Answer all questions – put a cross (x) in “Yes” or “No” boxes
Use BLOCK LETTERS or TYPEWRITER when completing this form

A	NAME/FIRST NAME/TITLE:					
B	PROPOSED ITINERARY (Airlines, flight number(s), class(es), date(s), segment(s), reservation status of continuous air journey)				Transfer from one flight to another often requires LONGER connecting time	
C	NATURE OF INCAPACITATION:					
D	IS STRETCHER NEEDED ONBOARD? (all stretcher cases MUST be escorted) No _____ Yes _____				Request rate if unknown.	
E	INTENDED ESCORTS (Name, sex, age) PNR if different, medical qualification, language spoken. If untrained state “TRAVEL COMPANION”				For blind and/or deaf, state if escorted by trained dog	
F	WHEELCHAIR NEEDED? No _____ Yes _____ Categories are: WCHR WCHS WCHC Wheelchair category: _____	Own wheelchair No _____ Yes _____	Collapsible No _____ Yes _____	Power driven No _____ Yes _____	Battery type (spillable?) No _____ Yes _____	Wheelchairs with spillable batteries are “Dangerous goods” and are permitted on passenger aircraft 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 _____ Yes _____				
		Specify ambulance company contacts				
		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 organization, (b) at whose expense, and (c) contact addresses/ telephone numbers where appropriate, or whenever specific persons are designated to meet/assist the passenger				
1.	Arrangements for delivery at airport of DEPARTURE: No _____ Yes _____					
2.	Arrangements for assistance at CONNECTING POINTS: No _____ Yes _____					
3.	Arrangements for meeting at airport of ARRIVAL: No _____ Yes _____	-ONLY FOR STCR- Specify the name & contact of meeting person/organization				
4.	Other requirements or relevant information No _____ Yes _____					
K	SPECIAL IN-FLIGHT ARRANGEMENTS NEEDED: special meals, special seating, leg rest, extra seat(s), special equipment etc. No _____ Yes _____	If yes, describe and indicate for each item: (a) segments(s) on which required, (b) airline-arranged or arranging third party, and (c) at whose expense. Provision of special equipment, such as oxygen, etc. always requires completion of MEDIF.				
L	DOES PASSENGER HOLD A FREQUENT TRAVELLER’ MEDICAL CARD (FREMEC)? No _____ Yes _____	If yes, add below FREMEC data to your reservation requests. If no (or if addition data needed by carrying airline(s)) have physician in attendance to complete the MEDIF.				
		FREMEC №	Issued by	Valid until	Sex	Age
		Incapacitation				
		Limitations				