

# AURIC AIR SERVICES LTD



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## MEDIF MEDICAL INFORMATION FORM FOR AIR TRAVEL

<b>PART 1</b> To be completed by <b>PASSENGER or AGENT</b>		<b>PLEASE WRITE CAPITAL LETTERS USING BLACK INK</b>							
<b>A</b>	<b>PASSENGER'S FULL NAME</b>								
<b>B</b>	<b>PROPOSED ITINERARY</b> (Airline(s), flight number(s), route(s), date(s) of continuous air travel)								
<b>C</b>	<b>NATURE OF DISABILITY, ILLNESS OR INJURY</b>								
<b>D</b>	<b>INTENDED ESCORT</b> (name, sex, age, professional qualification, flight /route if different from passenger) - If untrained, state "TRAVEL COMPANION"								
<b>2</b>	Is the intended escort capable and prepared to provide all assistance including lifting as required?	YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>E</b>	<b>WHEEL CHAIR NEEDED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> If YES indicate category: <b>WCHR:</b> cannot walk far but can manage stairs <input type="checkbox"/> <b>WCHS:</b> cannot walk far cannot manage stairs <input type="checkbox"/> <b>WCHC:</b> unable to walk <input type="checkbox"/>	Own Wheelchair?	Manual?	Power Driven?	Battery type? (Spill able?)	Wheelchair weight	Wheelchair Dimensions (cm)	Wheelchairs with spillable batteries are "restricted articles" and are permitted on passenger aircraft only under certain conditions.	
		YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>	___ Kgs	W _____		
		NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>		D _____		
							H _____		
<b>F</b>	<b>AMBULANCE NEEDED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	Specify ambulance company contacts							
		Specify destination address							
<b>G</b>	<b>OTHER GROUND ARRANGEMENTS NEEDED</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	If yes, SPECIFY below and indicate against each item: (a) the ARRANGING airline or other organization, (b) CONTACT address /phone where appropriate, or whenever specific persons are designated to meet/assists the passenger.							
	1. Arrangements for arrival at airport of departure	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<b>Specific:</b>					
	2. Arrangements or assistance at connecting points	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<b>Specific:</b>					
	3. Arrangements for meeting at airport of arrival	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<b>Specific:</b>					
	4. Other requirements or relevant information	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<b>Specific:</b>					
<b>H</b>	<b>SPECIFIC IN FLIGHT ARRANGEMENTS NEEDED</b> YES <input type="checkbox"/> NO <input type="checkbox"/> Requests such as seating, extra seat, extension belt, equipment, etc. (subject to availability).	If yes, DESCRIBE and indicate for each item: (a) FLIGHT ROUTE on which required, (b) airline-ARRANGED or arranging third party and (c) at whose expense. Provision of SPECIFIC EQUIPMENT, such as oxygen etc. always requires completion of PART 2 overleaf							
		(a) _____							
		(b) _____							
		(c) _____							
<b>PASSENGER'S DECLARATION</b>									
(Name of nominated medical doctor in CAPITAL LETTERS)									
"I HEREBY AUTHORISE .....									
To provide the airline with the information required by those airlines' Medical Provider for the purpose of determining my fitness to fly by air and in consideration thereof, I hereby agree to meet such doctor's fees in connection therewith. I take note that, if accepted for the carriage, my journey will be subject to the general conditions of carriage/tariffs of the carrier concerned and that the carrier does 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 carriage upon demand for any special expenditures or costs in connection with my carriage. I hereby authorize <b>Auric Air Tanzania Ltd.</b> to send a copy of this authorization to my medical doctor indicating my consent. " (Where needed, to be read by/to the passenger, dated and signed by him/her, or on his/her behalf)									
Date (DD/MM/YY)	Passenger's signature	If your medical condition/travel details change in any way prior to travelling, you are requested to contact auric air.							

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<b>PART 2</b> This form is intended to provide CONFIDENTIAL information to assess the fitness of the passenger. If the passenger can be transported, this information will facilitate the issuance of the necessary directives. To be completed by <b>ATTENDING PHYSICIAN/NOMINATED PHYSICIAN</b>  The ATTENDING PHYSICIAN of the incapacitated passenger is requested to <b>ANSWER ALL QUESTIONS.</b> <b>ENTER</b> and " <b>X</b> " in the appropriate " <b>Yes</b> " or " <b>No</b> " box and give concise answers.  PLEASE COMPLETE THE FORM IN CAPITAL LETTERS USING BLACK INK		RECORD LOCATOR NUMBER (PNR)          DATE of Travel (DD/MM/YY)
<b>MEDA 01</b>	<b>PASSENGER'S FULL NAME</b> _____ <span style="float: right;">SEX: M <input type="checkbox"/> F <input type="checkbox"/></span> <span style="float: right;">Date Of Birth(DD/MM/YY)</span>	
<b>MEDA 02</b>	<b>ATTENDING PHYSICIAN</b> Name, address and phone number _____	
<b>MEDA 03</b>	<b>DIAGNOSIS/MEDICAL DETAILS</b> (e.g. types of operation) Date of surgery/procedure(DD/MM/YY) <b>Vital signs</b> BP: _____ Pulse: _____ Temp: _____ SAO2 (on air) _____ % Date taken (DD/MM/YY)	
<b>MEDA 04</b>	Prognosis for the flight (s)	
<b>MEDA 05</b>	Is <b>PASSENGER FREE FROM</b> contagious <b>AND/OR</b> Communicable disease? YES <input type="checkbox"/> NO <input type="checkbox"/> Specify: _____	
<b>MEDA 06</b>	Would the physical and/or mental condition of the Passenger cause distress or discomfort to other Passenger? YES <input type="checkbox"/> NO <input type="checkbox"/> Specify: _____	
<b>MEDA 07</b>	Can the passenger use a normal aircraft seat with Seatback placed in the Upright position when so Required? YES <input type="checkbox"/> NO <input type="checkbox"/> Traveling via stretch? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>MEDA 08</b>	Can the passenger take care of their own needs on board <b>UNASSISTED</b> (Including mobility, etc.) YES <input type="checkbox"/> NO <input type="checkbox"/> <b>NOTE: if not refer to PART 1 (D2)</b>	
<b>MEDA 09</b>	Does the passenger require <b>OXYGEN</b> in the aircraft or On Ground? YES <input type="checkbox"/> NO <input type="checkbox"/> 2 <input type="checkbox"/> or 4 <input type="checkbox"/> Ipm Standby via pulse dose? YES <input type="checkbox"/> NO <input type="checkbox"/> Does the passenger require <b>OXYGEN</b> in flight? YES <input type="checkbox"/> NO <input type="checkbox"/> 2 <input type="checkbox"/> or 4 <input type="checkbox"/> Ipm Continuous via pulse dose? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>MEDA 10</b>	Does the passenger need any <b>MEDICATION</b> other than self- administered (a) On ground and/or the use of special apparatus such as respirator, incubator, IV pump, monitor etc? (b) On board YES <input type="checkbox"/> NO <input type="checkbox"/> Specify: _____	
<b>MEDA 11</b>	List medications need during the flight: _____ Can these be administered independently? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>MEDA 12</b>	Does the passenger need <b>HOSPITALISATION</b> ? (a) During layover YES <input type="checkbox"/> NO <input type="checkbox"/> Receiving Hospital: _____ Telephone contact: _____	
<b>MEDA 13</b>	(if Yes indicate Arrangements made, or if No indicate "NO ACTION TAKEN") (b) Upon arrival at DESTINATION YES <input type="checkbox"/> NO <input type="checkbox"/> Receiving Hospital: _____ Telephone contact: _____	
<b>MEDA 14</b>	Other remarks or information in the interest of the Passenger's smooth and comfortable travel:	
<b>MEDA 15</b>	Other arrangements made by the attending physician:	
Date (DD/MM/YY)	Attending physician's signature	