

## ATTACHMENT B (To be Completed by Attending Physician)

### Information Form for Passengers Requiring Medical Clearance – MEDIF / Part 1

Note for the attending physician:

The details requested in here will be treated confidentially; they should enable the Medical Services of the airline(s), as it is their obligation, to judge by their specific 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 Service in issuing appropriate instructions for the patient's care which duly consider both his/her diagnosis and the special circumstances of the requested air journey. Kindly answer all questions by cross or in block letters, as necessary. I

|     |                                                                                                                                                                                                                                                              |                                           |                                          |                                                                                     |
|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------|-------------------------------------------------------------------------------------|
| 1.  | Patient's name                                                                                                                                                                                                                                               |                                           |                                          |                                                                                     |
|     | Date of Birth                                                                                                                                                                                                                                                | Sex                                       | Height                                   | Weight                                                                              |
|     |                                                                                                                                                                                                                                                              |                                           |                                          |                                                                                     |
| 2.  | Attending physician                                                                                                                                                                                                                                          |                                           |                                          |                                                                                     |
|     |                                                                                                                                                                                                                                                              |                                           |                                          |                                                                                     |
|     | Address                                                                                                                                                                                                                                                      |                                           |                                          |                                                                                     |
|     |                                                                                                                                                                                                                                                              |                                           |                                          |                                                                                     |
|     | e-mail                                                                                                                                                                                                                                                       | Telephone, indicate country and area code |                                          | Fax                                                                                 |
|     |                                                                                                                                                                                                                                                              |                                           |                                          |                                                                                     |
| 3.  | Diagnosis (including short history, onset of current illness, episode or accident and treatment, specify if contagious)                                                                                                                                      |                                           |                                          |                                                                                     |
|     |                                                                                                                                                                                                                                                              |                                           |                                          |                                                                                     |
|     |                                                                                                                                                                                                                                                              |                                           |                                          |                                                                                     |
|     | Nature and date of any recent and/or relevant surgery                                                                                                                                                                                                        |                                           |                                          |                                                                                     |
|     |                                                                                                                                                                                                                                                              |                                           |                                          |                                                                                     |
| 4.  | Current symptoms and severity                                                                                                                                                                                                                                |                                           |                                          | Date of onset                                                                       |
|     |                                                                                                                                                                                                                                                              |                                           |                                          |                                                                                     |
| 5.  | Will a 25% to 30% reduction in the ambient partial pressure of oxygen (relative hypoxia) affect the passenger's medical condition? (Cabin pressure to be the equivalent of a fast trip to a mountain elevation of 2.400 meters (8.000 feet) above sea level) |                                           |                                          |                                                                                     |
|     | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure                                                                                                                                                                   |                                           |                                          |                                                                                     |
|     |                                                                                                                                                                                                                                                              |                                           |                                          |                                                                                     |
| 7.  | Additional clinical information                                                                                                                                                                                                                              |                                           |                                          |                                                                                     |
|     | a. Anemia                                                                                                                                                                                                                                                    | <input type="checkbox"/> yes              | <input type="checkbox"/> no              | If yes, give recent result in grams of haemoglobin per litre                        |
|     | b. Psychiatric conditions                                                                                                                                                                                                                                    | <input type="checkbox"/> yes              | <input type="checkbox"/> no              | If yes, see Part 2                                                                  |
|     | c. Cardiac disorder                                                                                                                                                                                                                                          | <input type="checkbox"/> yes              | <input type="checkbox"/> no              | If yes, see Part 2                                                                  |
|     | d. Normal bladder control                                                                                                                                                                                                                                    | <input type="checkbox"/> yes              | <input type="checkbox"/> no              | If no, give mode of control                                                         |
|     | e. Normal bowel control                                                                                                                                                                                                                                      | <input type="checkbox"/> yes              | <input type="checkbox"/> no              |                                                                                     |
|     | f. Respiratory disorder                                                                                                                                                                                                                                      | <input type="checkbox"/> yes              | <input type="checkbox"/> no              | If yes, see Part 2                                                                  |
|     | g. Does the patient require oxygen at home?                                                                                                                                                                                                                  | <input type="checkbox"/> yes              | <input type="checkbox"/> no              | If yes, specify how much                                                            |
|     | h. Oxygen needed during flight?                                                                                                                                                                                                                              | <input type="checkbox"/> yes              | <input type="checkbox"/> no              | If yes, specify <input type="checkbox"/> 2 LPM <input type="checkbox"/> 4 LPM other |
|     | i. Seizure disorder                                                                                                                                                                                                                                          | <input type="checkbox"/> yes              | <input type="checkbox"/> no              | If yes, see Part 2                                                                  |
| 7.  | Escort                                                                                                                                                                                                                                                       |                                           |                                          |                                                                                     |
|     | a. Is the patient fit to travel unaccompanied?                                                                                                                                                                                                               | <input type="checkbox"/> yes              | <input type="checkbox"/> no              |                                                                                     |
|     | b. Is the patient able to sit in a usual aircraft seat?                                                                                                                                                                                                      | <input type="checkbox"/> yes              | <input type="checkbox"/> no              |                                                                                     |
|     | c. Is the patient able to embark/disembark independently?                                                                                                                                                                                                    | <input type="checkbox"/> yes              | <input type="checkbox"/> no              |                                                                                     |
|     | d. If no, will the patient have a private escort to take care of his/her needs onboard?                                                                                                                                                                      | <input type="checkbox"/> yes              | <input type="checkbox"/> no              |                                                                                     |
|     | e. If yes, who should escort the passenger?                                                                                                                                                                                                                  | <input type="checkbox"/> Doctor           | <input type="checkbox"/> Nurse/Paramedic | <input type="checkbox"/> Other                                                      |
|     | f. If other, is the escort fully capable to attend to all above needs?                                                                                                                                                                                       | <input type="checkbox"/> yes              | <input type="checkbox"/> no              |                                                                                     |
| 8.  | Mobility                                                                                                                                                                                                                                                     |                                           |                                          |                                                                                     |
|     | a. Able to walk without assistance                                                                                                                                                                                                                           | <input type="checkbox"/> yes              | <input type="checkbox"/> no              |                                                                                     |
|     | b. Wheelchair required for boarding                                                                                                                                                                                                                          | <input type="checkbox"/> to aircraft      | <input type="checkbox"/> to seat         |                                                                                     |
| 9.  | Medication list (incl. doses)                                                                                                                                                                                                                                |                                           |                                          |                                                                                     |
|     |                                                                                                                                                                                                                                                              |                                           |                                          |                                                                                     |
| 10. | Other medical information                                                                                                                                                                                                                                    |                                           |                                          |                                                                                     |
|     |                                                                                                                                                                                                                                                              |                                           |                                          |                                                                                     |

**ATTACHMENT B (To be Completed by Attending Physician)**
**Information Form for Passengers Requiring  
Medical Clearance – MEDIF / Part 2**

|    |                                                                                                                               |                                                                                                 |                                                                                         |
|----|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| 1. | <b>Cardiac condition</b>                                                                                                      |                                                                                                 |                                                                                         |
|    | a. Angina                                                                                                                     | <input type="checkbox"/> yes <input type="checkbox"/> no                                        | When was last episode? _____                                                            |
|    | > Is the condition stable?                                                                                                    | <input type="checkbox"/> yes <input type="checkbox"/> no                                        |                                                                                         |
|    | > Functional class of the patient?                                                                                            | <input type="checkbox"/> No symptoms <input type="checkbox"/> Angina with moderate exertion     |                                                                                         |
|    |                                                                                                                               | <input type="checkbox"/> Angina with minimal exertion <input type="checkbox"/> Angina at rest   |                                                                                         |
|    | > Can the patient walk 100 metres at a normal pace or climb 10-12 stairs without symptoms?                                    | <input type="checkbox"/> yes <input type="checkbox"/> no                                        |                                                                                         |
|    | b. Myocardial infarction                                                                                                      | <input type="checkbox"/> yes <input type="checkbox"/> no                                        | Date _____                                                                              |
|    | > Complications?                                                                                                              | <input type="checkbox"/> yes <input type="checkbox"/> no                                        | If yes, give details _____                                                              |
|    | > Stress EKG done?                                                                                                            | <input type="checkbox"/> yes <input type="checkbox"/> no                                        | If yes, what was the result? _____ MET or _____ Watt                                    |
|    | > If angioplasty or coronary bypass, can the patient walk 100 metres at a normal pace or climb 10-12 stairs without symptoms? | <input type="checkbox"/> yes <input type="checkbox"/> no                                        |                                                                                         |
| 2. | <b>Chronic pulmonary condition</b>                                                                                            |                                                                                                 |                                                                                         |
|    | a. Has the patient had recent arterial blood gases?                                                                           | <input type="checkbox"/> yes <input type="checkbox"/> no                                        |                                                                                         |
|    | b. Blood gases were taken on                                                                                                  | <input type="checkbox"/> room air <input type="checkbox"/> Oxygen _____ litres per minute (LPM) |                                                                                         |
|    | If yes, what were the results _____                                                                                           | pCO <sub>2</sub> [kPa/mmHg] _____ pO <sub>2</sub> [kPa/mmHg] _____                              |                                                                                         |
|    |                                                                                                                               | % Saturation _____                                                                              | Date of exam _____                                                                      |
|    | c. Does the patient retain CO <sub>2</sub> ?                                                                                  | <input type="checkbox"/> yes <input type="checkbox"/> no                                        |                                                                                         |
|    | d. Has his/her condition deteriorated recently?                                                                               | <input type="checkbox"/> yes <input type="checkbox"/> no                                        |                                                                                         |
|    | e. Can patient walk 100 metres at a normal pace or climb 10-12 stairs without symptoms?                                       | <input type="checkbox"/> yes <input type="checkbox"/> no                                        |                                                                                         |
|    | f. Has the patient ever taken a commercial aircraft in his/her current medical status?                                        | <input type="checkbox"/> yes <input type="checkbox"/> no If yes, when? _____                    |                                                                                         |
|    | > Did the patient have any problems?                                                                                          | _____                                                                                           |                                                                                         |
| 3. | <b>Psychiatric conditions</b>                                                                                                 |                                                                                                 |                                                                                         |
|    | a. Is there a possibility that the patient will become agitated during flight?                                                | <input type="checkbox"/> yes <input type="checkbox"/> no                                        |                                                                                         |
|    | b. Has he/she taken a commercial aircraft before?                                                                             | <input type="checkbox"/> yes <input type="checkbox"/> no If yes, date of travel? _____          | Did the patient travel <input type="checkbox"/> alone <input type="checkbox"/> escorted |
| 4. | <b>Seizure</b>                                                                                                                |                                                                                                 | <input type="checkbox"/> yes <input type="checkbox"/> no                                |
|    | a. What type of seizures?                                                                                                     | _____                                                                                           |                                                                                         |
|    | b. Frequency of the seizures                                                                                                  | _____                                                                                           |                                                                                         |
|    | c. When was the last seizure?                                                                                                 | _____                                                                                           |                                                                                         |
|    | d. Are the seizures controlled by medication?                                                                                 | <input type="checkbox"/> yes <input type="checkbox"/> no                                        |                                                                                         |
| 5. | <b>Prognosis for the trip</b><br>(Fit to Travel)                                                                              |                                                                                                 | <input type="checkbox"/> Good <input type="checkbox"/> Poor<br>yes no                   |

Physician signature (or facsimile) \_\_\_\_\_

Date \_\_\_\_\_

**Note:** Cabin attendants are not authorized to give special assistance (e.g. lifting, feeding aid) 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 give 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.