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APPLICATION SHEET FOR PASSENGER REQUIRING SPECIAL ASSISTANCE

ATTACHMENT A *(service instructions for airline passengers) PART 1*

Please answer all the questions and mark the appropriate fields with a sign (X) for YES or NO. You must complete the MEDIF form in CAPITAL letters.

Name, first name			**Title**	**Gender**	**Age**
Passenger name record (PNR)					
Flight number	**Routing from**		**Routing to**	**Date**	
Flight number	**Routing from**		**Routing to**	**Date**	
Type of disability					
Need to use a stretcher on board	☐ **NO**	☐ **YES**	*there is an additional charge for stretcher transportation*		
Escort for the journey required	☐ **NO**	☐ **YES**			
Medical qualification	☐ **none**	☐ **nurse**	☐ **doctor**		
Name, first name			**PNR**		
Wheelchair required	☐ **NO**	☐ **YES**			
Own wheelchair	☐ **NO**	☐ **YES**	☐	**WCHR – The passenger is able to climb the stairs**	
Folding WCOB	☐ **NO**	☐ **YES**	☐	**WCHS – The passenger is unable to climb the stairs**	
Powered by battery WCBD	☐ **NO**	☐ **YES**	☐	**WCHC – The passenger is unable to walk**	
Need ambulance	☐ **NO**	☐ **YES**	*Ambulance arrangement is not provided by Airline*		
Ambulance company data					
Needed oxygen during the flight	☐ **NO**	☐ **YES**			

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APPLICATION SHEET FOR PASSENGER REQUIRING SPECIAL ASSISTANCE

ATTACHMENT A *(service instructions for airline passengers) PART 2*

	The passenger has his own oxygen concentrator ☐ **NO** ☐ **YES**		
	If YES, tick the appropriate box ☐ **2 LPM** ☐ **4 LPM** ☐ **different (model, type POC)……**		
Other facilities at the airport ☐ **NO** ☐ **YES**			
If YES, indicate	**Departure Airport**	**Transit Airport**	**Destination airport**
Special facilities on board ☐ **NO** ☐ **YES**			
	If YES, indicate the necessary facilities *(special meal, extra space, extra legroom, etc.)*		
	If YES, specify the necessary equipment *(ventilator, incubator, oxygen, etc.)*		
Date of last medical examination *(carried out up to two weeks before the planned departure date)*			

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APPLICATION SHEET FOR PASSENGER REQUIRING SPECIAL ASSISTANCE

ATTACHMENT B *(to be completed by doctor) PART 1 A*

Please answer all the questions and mark the appropriate fields with a sign (X) for YES or NO. You must complete the MEDIF form in CAPITAL letters.

*The form is **confidential**. The information collected will allow you to assess your passenger's health and travel authorization. If you are allowed to travel, the collected data will allow you to make the necessary decisions, which are designed to meet the needs of the Passenger and ensure comfort during the flight. The passenger doctor is obliged to answer the MEDIF form.*

Passenger's name, first name	**Date of birth**	**Gender**	**Growth**	**Weight**

Main doctor	**Telephone**	**Address**	**e-mail**

Diagnosis *(current date of treatment, onset of illness, accident, treatment; You need to determine if the disease is infectious)*

Please indicate the nature of each recent study and treatment

Present symptoms and their severity

Will reducing the surrounding partial oxygen pressure by 25 - 30% (relative hypoxia) affect the patient's health? *(The cabin pressure is equivalent to a fast mountain journey up to 2,400 meters (8,000 feet) above sea level)*

☐ **NO** ☐ **YES** ☐ **LACK OF KNOWLEDGE**

Additional clinical information

	1. Anaemia	☐ **YES**	☐ **NO**	*If YES, hemoglobin levels in grams*
	2. Psychiatric disorders, seizures	☐ **YES**	☐ **NO**	*If YES, fill out Part Two*
	3. Cardiac problems	☐ **YES**	☐ **NO**	*If YES, fill out Part Two*

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APPLICATION SHEET FOR PASSENGER REQUIRING SPECIAL ASSISTANCE

ATTACHMENT B *(to be completed by doctor) PART 1 B*

	4. Problem with urination control	☐ **YES**	☐ **NO**	*If YES, provide a means of prevention*
	5. Problem with bowel control	☐ **YES**	☐ **NO**	
	6. Respiratory problems	☐ **YES**	☐ **NO**	*If YES, fill out Part Two*
	7. Does the passenger use oxygen at home	☐ **YES**	☐ **NO**	*If YES, indicate how many*
Escort				
	1. Is the passenger able to travel without care?	☐ **YES**	☐ **NO**	
	2. If NO, will the assurance provided by the carrier be sufficient?	☐ **YES**	☐ **NO**	
	3. If NO, will the passenger have his own assist to take care of his needs?	☐ **YES**	☐ **NO**	
	4. If YES, who will look after the passenger	☐ **Doctor**	☐ **Nurse**	☐ **Other**
	5. If Other, does this person provide assistance in all needs	☐ **YES**	☐ **NO**	
Mobility				
	1. Can the passenger walk without assistance?	☐ **YES**	☐ **NO**	
	2. If NO, do you need a wheelchair?	☐ **YES**	☐ **NO**	
	3. If YES, does the trolley need to	☐ boarding	☐ Moving around the board	

List of medications	**Other medical information**

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APPLICATION SHEET FOR PASSENGER REQUIRING SPECIAL ASSISTANCE

ATTACHMENT B *(to be completed by doctor) PART 2 A*

State of cardiovascular system

	1. Symptoms of coronary artery disease ☐ **YES** ☐ **NO**	*When was the last case?*
	• **Is the condition stable?** ☐ **YES** ☐ **NO**	
	• **Capacity level** ☐ **YES** ☐ **NO**	
	☐ no symptoms ☐ at large effort ☐ with light effort ☐ at rest	
	Can the passenger be able to go 100 meters normal pace or beat about 10 degrees without symptoms? ☐ **YES** ☐ **NO**	
	2. Myocardial infarction ☐ **YES** ☐ **NO**	*Date:*
	• **Complications** ☐ **YES** ☐ **NO**	*If YES, give details*
	• **Stress test** ☐ **YES** ☐ **NO**	*If YES, enter the result [METZ]*
	• **Has the passenger been treated invasively (by-pass)?** ☐ **YES** ☐ **NO**	
	Can the passenger be able to go 100 meters normal pace or beat about 10 degrees without symptoms? ☐ **YES** ☐ **NO**	
	3. Myocardial insufficiency ☐ **YES** ☐ **NO**	*When was the last case?*
	• **The degree of severity of myocardial failure**	
	☐ no symptoms ☐ breathlessness with great effort ☐ shortness of breath with light effort ☐ dyspnoea at rest	
	4. Syncope ☐ **YES** ☐ **NO**	
	5. Research ☐ **YES** ☐ **NO**	*If YES, please provide the result*

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APPLICATION SHEET FOR PASSENGER REQUIRING SPECIAL ASSISTANCE

ATTACHMENT B *(to be completed by doctor) PART 2 B*

Chronic lung disease		☐ **YES**	☐ **NO**	
	1. Last gasometer result			
	2. Results of saturation measurements			
	3. Is there CO2 retention?	☐ **YES**	☐ **NO**	
	4. Has the condition of the passenger recently worsened?	☐ **YES**	☐ **NO**	
	5. Can the passenger be able to pass 100 meters at normal pace or beat about 10 degrees without symptoms?	☐ **YES**	☐ **NO**	
	6. Did the passenger fly under similar health conditions?	☐ **YES**	☐ **NO**	
	• **If Yes, specify when**			
	• **If YES, did the passenger have problems during the flight?**			
Mental condition				
	1. Is there a likelihood that the passenger will be energized during the flight?	☐ **YES**	☐ **NO**	
	2. Did the passenger travel alone earlier by plane?	☐ **YES**	☐ **NO**	*If YES, please specify the date*
	3. The patient will travel	☐ alone	☐ with escort	

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APPLICATION SHEET FOR PASSENGER REQUIRING SPECIAL ASSISTANCE

ATTACHMENT B *(to be completed by doctor) PART 2 C*

Seizures	☐ **YES** ☐ **NO**	
	1. What are the types of seizures?	
	2. What is the frequency of seizures?	
	3. When was the last attack?	
	4. Is the passenger being treated? ☐ **YES** ☐ **NO**	
What is the condition of the passenger before the trip?		
Signature of the doctor *(readable)*		**Date**

IMPORTANT INFORMATION:

- *Cabin crew is not authorized to provide special assistance (eg lifting, handling, etc.) to individual passengers at the expense of other passengers. In addition, cabin crew are only trained to provide first aid and do not have the right to inject and administer medicines to passengers.*
- *Charges (if required) for selected services provided by the air carrier are borne by the passenger.*