



**DRUKAIR CORPORATION LIMITED**

**MEDIF**

PART 1 To be Completed By SALES OFFICE/AGENT		INCAPICATED PASSENGERS HANDLING ADVICE (INCAD) HANDLING INFORMATION – PART 1					Category	
		Answer ALL questions – put cross (x) in “Yes” or “No” boxes. Use BLOCK LETTERS or TYPE when completing this form						
A	NAME/INITIALS/TITLE							
	Last Name : ..... First Name : ..... Title : ..... Age : .....							
B	PROPOSED ITINERARY (airline(s), flight number(s), class(es), Date(s), segment(s), reservation status of continuous air journey)	1 <sup>st</sup> Flight No: KB..... From..... To..... Date..... 2 <sup>nd</sup> Flight No: KB..... From..... To..... Date.....						
C	Nature of INCAPICITATION/ILLNESS:		MEDICAL CLERANCE REQUIRED?			<input type="checkbox"/> No <input type="checkbox"/> Yes		
D	IS STRETCHER NEEDED on BOARD? (all stretcher cases MUST be escorted)	<input type="checkbox"/> No <input type="checkbox"/> Yes			Request rate if unknown			
E	INTENDED ESCORT (name, sex, age, professional qualifications, segments if different from passenger) If untrained, state “TRAVEL COMPANION”	Last name : ..... First name : ..... Sex:..... Age : ..... Doctor/Nurse/Paramedic..... PNR : ..... Last name : ..... First name : ..... Sex:..... Age : ..... Doctor/Nurse/Paramedic..... PNR:.....						
F	WHEELCHAIR NEEDED?  Categories are *WCHR *WCHS *WCHC Wheelchair category:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Own Wheelchair	Collapsible	Power driven?	Battery Type (Spillable?)	Wheelchair with spillable batteries is “restricted articles” and are permitted on passenger aircraft only under certain conditions, which can be obtained from the airline(s). In addition, certain countries may impose specific restriction.	
	<input type="checkbox"/> WCHR <input type="checkbox"/> WCHS <input type="checkbox"/> WCHC	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes		
G	Ambulance Needed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	To be arranged by PHYSICIAN AND/OR PATIENT  No Specify ambulance company contact: Yes Specify destination address:				Request rate(s) if unknown	
H	OTHER GROUND ARRANGEMENTS NEEDED	<input type="checkbox"/> No <input type="checkbox"/> YES	If yes, SPECIFY below and indicate for each item: (a) the ARRANGING airline or other organizations. (b) at whose EXPENSE, and (c) CONTACT addresses/phone numbers where appropriate, or whenever specific persons are designed to meet/assist the passenger.					
H1	Arrangement for delivery at airport of DEPARTURE	<input type="checkbox"/> No <input type="checkbox"/> Yes	Specify					
H2	Arrangement for assistance at CONNECTING POINTS	<input type="checkbox"/> No <input type="checkbox"/> Yes	Specify					
H3	Arrangement for meeting at airport of ARRIVAL	<input type="checkbox"/> No <input type="checkbox"/> Yes	Specify					
H4	Other requirements or relevant information	<input type="checkbox"/> No <input type="checkbox"/> Yes	Specify					
I	SPECIAL IN-FLIGHT ARRANGEMENTS NEEDED such as: special meals, special seating, leg-rest, extra seat(s), special equipment, etc. (See Note* at the end of PART 2 overleaf)	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, DESCRIBE and indicate for each item: (a) SEGMENT(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 PART 2 overleaf.					
	(Incapacitation continued)	(Limitations)						
	*WCHR = passenger cannot walk well but can use stairs, *WCHS = passenger cannot walk up and down stairs, *WCHC = passenger cannot walk at all.							

KB – 3D



DRUKAIR CORPORATION LIMITED

CONFIDENTIAL

PART 2		MEDICAL INFORMATION FORM – MEDIF				For Official use only		
<p>To be completed By <b>ATTENDING PHYSICIAN</b></p>		<p>This form is intended to provide CONFIDENTIAL information to enable the airlines 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.</p> <p>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 answers.</p> <p>In CASE OF HIV POSITIVE PATIENT, THE LATEST CHEST X-RAY RESULT SHOULD BE ATTACHED TO THIS MEDICAL INFORMATION FORM.</p> <p>COMPLETING OF THE FORM IN BLOCK LETTERS OR BY TYPING WILL BE APPRECIATED</p>				<p>Please return the completed form to</p>		
						<p>ADDRESS OF KB ISSUING OFFICER</p>		
		MEDA01	PATIENT'S NAME, INITIAL(S), SEX, AGE					
		MEDA02	ATTENDING PHYSICIAN		Name: _____ Address: _____			
	<p>- Name &amp; Address</p> <p>- Telephone Contact</p>		Business: _____ Home: _____					
MEDA03	<p>MEDICAL DATE:</p> <p>- DIAGNOSIS and TREATMENT in details.</p>							
	<p>- Latest vital signs:</p> <p>- Day/month/year of first symptom:</p>		BP = /	PR=	RR=	TEMP=		
			Date of diagnosis:		Spo2=	Date		
MEDA04	<p>PROGNOSIS for the flight(s): <input type="checkbox"/> GOOD (No problem Anticipated) <input type="checkbox"/> GUARDED (Potential problems) <input type="checkbox"/> POOR (Problems likely)</p>							
MEDA05	Contagious AND communicable disease?		<input type="checkbox"/> No <input type="checkbox"/> Yes		Specify:			
MEDA06	Would the physician and/or mental condition of the patient be likely to cause distress or discomfort to other passengers?		<input type="checkbox"/> No <input type="checkbox"/> Yes		Specify:			
MEDA07	Can patient use normal aircraft seat with seatback placed in the UPRIGHT position when so required?		<input type="checkbox"/> No <input type="checkbox"/> Yes					
MEDA08	Can patient take care of his own needs on board UNASSISTED *(INCLUDING meals, visit to toilet, etc)?		<input type="checkbox"/> No <input type="checkbox"/> Yes					
MEDA09	If to be ESCORTED is the arrangement satisfactory to you?		<input type="checkbox"/> No <input type="checkbox"/> Yes					
			If not, type of escort proposed by YOU					
MEDA10	Does patient need OXYGEN**equipment in flight? (if yes, state rate of flow).		<input type="checkbox"/> No <input type="checkbox"/> Yes		Liters per minute..... Continuous <input type="checkbox"/> No <input type="checkbox"/> Yes			
MEDA11	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):					
MEDA12			<input type="checkbox"/> No <input type="checkbox"/> Yes Specify					
			(b) On board of the AIRCRAFT?					
			<input type="checkbox"/> No <input type="checkbox"/> Yes Specify					
MEDA13	Does patient need HOSPITALISATION? (If yes, indicate arrangements made or, if none were made, indicate "NO ACTION TAKEN") NOTE: The attending physician and/or patients is responsible for all arrangements.		(a) During long layover or nightstop at CONNECTING POINTS en route:					
MEDA14			<input type="checkbox"/> No <input type="checkbox"/> Yes Action:					
			Upon arrival at DESTINATION:					
			<input type="checkbox"/> No <input type="checkbox"/> Yes Action:					
MEDA15	Other remarks or information in the interest of your patient's smooth and comfortable transportation:		<input type="checkbox"/> None Specify if any**					
MEDA16	Other arrangements made by the attending physician:							
MEDA17	Cabin Attendants are NOT authorized to give special assistance to particular passengers, to determine 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 and for carrier-provided special equipment (** are to be paid by the passenger concerned.				
Place:		Date:		Attending Physician's Signature:				

<b>PART 3</b>		<b>MEDICAL INFORMATION FORM – MEDIF</b>				
To be completed By <b>ATTENDING PHYSICIAN</b>		This is for transportation purposes only. We, the Airline, give medical authorization for the passenger's air travel, depending on the following documentation provided by you, the attending physician. Please make sure the attending physician of the patient fills out all applicable items below for patient's safe and healthy journey. If needed, we will contact to the attending physician for further information. This form is only to evaluate the patient passenger's health status, and will be used for the patient passenger's air travel.				
3.1	Patient	Name:	Age:	M/F	Height(cm):	Weight(kg):
3.2	A. Mental Status	<input type="checkbox"/> Alert <input type="checkbox"/> Drowsy <input type="checkbox"/> Stupor <input type="checkbox"/> Semi-coma   GCS Score:   E   V   M Pupil size   /   mn   ( <input type="checkbox"/> react <input type="checkbox"/> sluggish <input type="checkbox"/> not react)				
	B. Physical Examination	Respiratory				
		Cardiovascular				
		Neurological				
	C. Underlying disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, (please specify)		
	D. Hospitalization operation/procedure	Did this patient have surgery/Medical procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of operation/procedure: _____ Is there any complication after surgery/procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No Has/Had this patient been admitted to the hospital recently? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where? <input type="checkbox"/> ICU <input type="checkbox"/> General Ward <input type="checkbox"/> ER <input type="checkbox"/> Other (Please specify) _____ Hospitalization date: _____   Discharge date: _____				
3.3	Medication	Does this patient take any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Orally <input type="checkbox"/> IV or IM <input type="checkbox"/> Other   * Medication list must be provided in Medical report Will this patient take the medications (noted above) during flight?				
3.4	Medical Equipment during flight	<input type="checkbox"/> None <input type="checkbox"/> IV Line <input type="checkbox"/> Foley Catheter <input type="checkbox"/> Nasogastric tube <input type="checkbox"/> Chest tube <input type="checkbox"/> Endotracheal tube <input type="checkbox"/> Trachesotomy <input type="checkbox"/> Suction Kit <input type="checkbox"/> Oxymeter <input type="checkbox"/> Infusion pump <input type="checkbox"/> Nebulizer <input type="checkbox"/> Portable Oxygen concentrator <input type="checkbox"/> Ventilator (Setting:.....) Brand and Model:..... <input type="checkbox"/> Splint/Cast <input type="checkbox"/> Other *In case of medical equipment use, please notify the equipment model to KB reservations centre. *Any necessary supply of electricity should be from battery power only. *IV fluid should be prepared in plastic bag				
<b>NOTE* Please attached OFFICIAL medical summary or currently medical report, FIT to FLY Certificate and test result. (Blood test or image test, etc) related to the patient's disease with hospital stamp.</b>						
Available Contact Number:		Date:		Attending Physician signature: (Hospital Stamp)		
<b>PHYSICIAN APPROVAL</b>		<input type="checkbox"/> Approved <input type="checkbox"/> Rejected <input type="checkbox"/> Need Details  <b>Remarks:</b>				



**DRUKAIR CORPORATION LIMITED**

**CONFIDENTIAL**

<b>PART 4</b>	<b>INDEMNITY FORM – MEDIF</b>	
To be completed By <b>PATIENT</b>		
<b>PASSENGER DECLARATION</b>	<p><b>PASSENGER'S DECLARATION</b>          "I HEREBY AUTHORIZE .....(name of nominate physician)</p> <p>To provide the airlines with the information required by those airlines for the purpose of determining my fitness for carriage by air and consideration thereof I hereby relieve that physician of his/her professional duty of confidentiality in respect of such information.</p> <p>I take note that, if accepted for 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.</p> <p>In the event of sudden change of my medical condition prior to the journey, I agree to notify the carrier and to submit the updated medical information/medical report or MEDIF to the carrier to prevent unforeseen in-flight medical events.</p> <p>I, the undersigned will indemnify and release the carrier from and against all loss of damage sustained owing to accepting me for carriage considering my medical incapacitation, and against all costs and expenses (including Lines, detention, diversion, deportation or quarantine costs etc.) incurred.</p> <p>I am aware that I am responsible for the expenditures, incurred due to my cancellation of the service during travelling, for any arrangement relevant to the provision of the service which has been previously agreed.</p> <p>I am prepared, at my own risk, to bear any consequences which carriage by air may have on my state of health and I release the carriers, the physician, employees, servants and agents from any liability for such consequences.</p> <p><b>I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENTS AND AGREE TO THEM FULLY</b>          (Where needed, to be read by the passenger, dated and signed by him/her, or on his/her behalf)</p>	
<b>Place:</b>	<b>Date:</b>	<b>Passenger's Signature:</b>

KB - 3D