FIJI AIRWAYS

MEDICAL INFORMATION
TO BE COMPLETED BY THE PASSENGER (PLEASE PRINT IN BLOCK CAPITAL LETTERS)

PART 1
Doctors/Office use only

1. Family name _____ Given name _____ Title _____ Age _____

2. Address _____ Telephone contact No. _____

3. Proposed Itinerary: Flt. No._____ Date _____ From _____ To _____

4. Whats is the **nature** and **duration** of your illness/injury _____

_____

5. If you are being escorted, please provide details of your escort:

   Name _____ Title_____ Age _____ Qualifications _____

6. Do you require a wheelchair? for long distances ☐ to aircraft door ☐ to aircraft seat ☐

7. Would you prefer Aisle seat ☐ seat near toilet ☐

8. Do you need an ambulance Yes ☐ No ☐

   All ambulances have to be arranged by the treating doctor/hospital/evacuation company. Clearance CANNOT be given until bookings are confirmed.

9. Have ambulance transfers been confirmed in Departure port ☐ Transit port ☐ Arrival port ☐

10. Do you have a life-threatening allergy to any food types?

    Please specify _____

11. Do you need to use electrical equipment powered by the aircraft supplies? Yes ☐ No ☐

    Please specify _____

OFFICE USE ONLY

Ref. No.

Information Complete ☐

Clearance not required ☐

Type of assistance required
- Ground ☐
- Wheel chair ☐
- Stretcher ☐
- Escort ☐

Oxygen required ☐
- 2L/m ☐
- 4L/m ☐
- continuous ☐
- intermittent ☐

No. of cylinders need ☐

Medical equipment required ☐

Equipment approved ☐

Approved for uplift ☐
Dr's sig.
Date
Time

Approved for uplift ☐
Reeservation
Date
Time

PASSENGER'S DECLARATION

I HEREBY AUTHORISE _____

(Name of treating doctor)

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 therefore I hereby relieve the physician of his/her professional duty of confidentiality in respect of such information, and agree to meet such physician's fee in connection therewith.

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 agents and doctors from any such liability for such consequence.

PASSENGER'S SIGNATURE _____ Date _____ Place _____

FIJI AIRWAYS

MEDICAL INFORMATION
TO BE COMPLETED BY YOUR DOCTOR (PLEASE PRINT IN BLOCK CAPITAL LETTERS)

PART 2
Doctors/Office use only

1. Patient's Family Name _____ First name _____ Date of birth _____ Sex _____
2. Treating physician 's name and address _____
   Telephone contact: Business _____ A/H (Mobile) _____
3. Medical diagnosis (in detail) _____

   _____

   Date of first symptoms _____ Date of diagnosis _____ Date of Surgery _____

Anemia	Nil	☐	Mild	☐	Moderate	☐	Severe	☐
Dyspnoea	Ni l	☐	Mild	☐	Moderate	☐	Severe	☐
Pain	Nil	☐	Mild	☐	Moderate	☐	Severe	☐

Blood pressure

4. Prognosis for the journey? Poor ☐ Fair ☐ Good ☐ Excellent ☐
5. Any contagious or communicable disease? Yes ☐ No ☐
6. Has passenger control of: bowel Yes ☐ No ☐
   bladder Yes ☐ No ☐
7. Is your patients condition (physical or mental) likely to cause distress or discomfort to other passengers? Yes ☐ No ☐
8. Has your patient had suicidal tendencies Yes ☐ No ☐
   been violent or required restraint Yes ☐ No ☐
   become noisy or agitated Yes ☐ No ☐
9. Js your patient pregnant? Yes ☐ No ☐ Expected date of confinement _____
   Are there any pregnancy related problems? Yes ☐ No ☐ Details _____
10. Can your patient sit for the proposed journey with the seat fully upright? Yes ☐ No ☐
    If no then the patient will need a stretcher at an additional cost to the patient
11. Can your patient walk to and board the aircraft Yes ☐ No ☐
    walk to the toilet unassisted Yes ☐ No ☐
    use the toilet unassisted Yes ☐ No ☐
    feed himself/herself unassisted Yes ☐ No ☐

    Flight attendants are unable to give special assistance with toileting and feeding
12. Does your patient need any treatment during the journey Yes ☐ No ☐ Details _____

    _____
13. Does your patient need to be accompanied? Yes ☐ No ☐
    Is a medically trained escort necessary? Yes ☐ No ☐
14. Will oxygen be required during the journey? Yes ☐ No ☐ L/m Continuous ☐ Intermittent ☐
15. Is medical equipment to be used in flight? Yes ☐ No ☐ Please List _____
16. Having read the guiding principals, you are of the opinion that this patient is medically FIT/UNFIT to undertake the contemplated journey by air without causing any inconvenience or embarrassment to other passengers.

DOCTOR'S SIGNATURE _____ Date _____ Place _____