Air North Medical Form

Please fill out this form completely to avoid processing delays and submit it to medical@flyairnorth.com. We ask that requests be made 72 hours prior to travel, but in emergency situations we may be able to accommodate if less then 72 hours notice. Once your form is submitted, please contact us at 1.800.661.0407 (toll-free in North America) or (867)668.2228 to advise us an application has been submitted.

Patient information

Last name (as shown on travel I.D)_____ First name _____

Middle name_____ Birthday (MM/DD/YYYY)_____

Gender _____ E-mail_____ Phone _____

Address _____ City _____

Province _____ Postal code _____ Country _____

Travel date (MM/DD/YYYY) _____ Flight origin _____ Flight destination_____

Alternate contact

Please provide an alternate contact if the patient is a child or cannot advocate for themselves. The alternate contact will have access to this medical information and be able to provide details regarding your patient's medical history on the patient's behalf.

Name_____ Relationship _____

E-mail_____ Phone _____

Previous travel history

Have you ever flown in a commercial aircraft with the medical condition detailed on this form? ◯ Yes ◉ No

Have you suffered any medical complications that required medical intervention during a commercial flight? ◯ Yes ◉ No

If yes, please provide details

_____

Patient consent and agreement

I consent to the collection, disclosure, and retention of the medical information on this form and/or information related to an on-board medical event for the purposes of facilitating safe travel. I consent and authorize Air North and my treating medical professionals to provide, receive, and discuss the information on this form, other medical information, or my previous and/or future travel history with Air North as required to facilitate my safe air travel with Air North. For this purpose, I agree that Air North may disclose to my treating medical professional's information related to on-board medical event(s) which may have occurred prior or after my signing of this consent and authorization. This consent and authorization extends to any medical professional holding information relevant to my assessment and/or ability to fly safely with Air North, which may or may not be the same physician listed in this form, or any support organization arranging travel on my behalf. I agree to provide updated medical information for any significant change(s) to my health and/or if I experience an on-board medical event I also agree to abide by the terms of any medical accommodation including personal attendant requirements and restrictions applicable to travel companions.

Signature (patient or guardian) _____ **Date (MM/DD/YYYY)**_____

Pages 2-5 are to be filled out by a medical physician

Physician details

Physician name_____ License number_____

Province/Country of registration_____ City _____

E-mail (optional) _____ Phone _____ Fax _____

Date of first visit MM/DD/YYYY _____ Is your patient regularly in your care? ◯ Yes ◯ No

Please indicate any of the following regarding your patient:

☐ Anemia

☐ Requires an attendant

☐ Requires an extra seat for obesity

☐ Requires a buffer zone on board due to severe allergy

☐ Has an active communicable disease that can pose a direct threat to the health and safety of others during the normal course of their travel

☐ Is affected by a decrease in pressure of oxygen

If yes, please explain

_____

_____

_____

_____

What is the prognosis for a safe flight requiring no extraordinary medical attention? Indicate poor if your patient has an unstable medical condition, a condition that may worsen at altitude, or requires medical assistance or emergency equipment during flight.

◉ Good ◯ Poor

Physician Office Stamp

Physician consent

By signing this form, I understand that I am providing information which Air North will use to determine my patient's ability and/or accommodations needed to travel safely. I accordingly certify that all of the information I have provided is complete, true and accurate to the best of my knowledge.

Signature (physician) _____ Date MM/DD/YYY_____

Declaration of medical conditions

Patient name_____

Diagnoses_____ Date of onset (DDMMYYYY)_____

Current symptoms_____

Treatment/prescribed medications _____

Recent, relevant or planned hospitalization ◯ Yes ◯ No Reason _____
Date _____

Is the patient currently hospitalized? ◯ Yes ◉ No If yes, will they be discharged to: ◯ Home ◯ Facility on
Date_____

☐ Allergies

(Complete only if your patient has a severely debilitating/life threatening allergy that requires a buffer zone accommodation on board the aircraft).
Please indicate if your patient suffers from any of the following:

☐ Hives

☐ Sneezing

☐ Anaphylaxis

☐ Asthma attacks

Notes

_____

_____

☐ Pulmonary

Please indicate if your patient suffers from any of the following:

☐ Shortness of breath at rest

☐ Shortness of breath walking 50m+

☐ Uses Oxygen at home
saturation %_____ L/min continuous oxygen_____
Oxygen tank or Personal oxygen concentrator_____

☐ Recent deterioration due to pulmonary condition

Will your patient bring their own POC on board for use during their flight? ◯ Yes ◉ No

Can your patient fully manage their POC during flight including responding to alerts and battery exchange? ◯ Yes ◉ No

Does your patient have enough batteries to last at least 1.5 times duration of their flight? ◯ Yes ◉ No

Notes _____

Cardiac Please indicate if your patient suffers from any of the following:

Condition type _____

- ☐ Needs continuous oxygen
- ☐ Angina Date_____
- ☐ Myocardial infraction Date_____
- ☐ Angiogram/Angioplasty/Bypass Date_____
- ☐ Cardiac failure Date_____

Please indicate if your patient is stable and other relevant details:

_____
_____
_____

Seizures Please indicate if your patient suffers from any of the following:

Type _____ Frequency _____ Duration _____

Date of last seizure_____

Are the seizures stable and controlled by medicine? ◯ Yes ◯ No

Is oxygen or suction required to manage the seizure? ◯ Yes ◉ No

What action is taken to manage the seizure? _____

Cognitive/behavioural or psychiatric

Condition type/explanation

_____
_____
_____

Is your patient alert X3 to person, place and time? ◯ Yes ◯ No

Is there a possibility they will deteriorate while waiting at the airport? ◉ Yes ◯ No

Is there a possibility they will deteriorate on a flight? ◯ Yes ◯ No

☐ **Mobility** Do not use this form to request the use of a wheelchair. See our website https://www.flyairnorth.com/specialized-assistance for advance notice requirements and more information. We cannot accommodate persons who exceed 200 kg (440 pounds) and require a transfer. For a list of mobility aids visit https://www.flyairnorth.com/specialized-assistance/accessibility-and-mobility.

Does your patient require a wheelchair for:

☐ Distance ☐ Unable to ascend/descend steps ☐ At all times

Can your patient self-transfer to/from a wheelchair to the seat of the aircraft? ◉ Yes ○ No

Can your patient stand, pivot and weight bear? ○ Yes ○ No

☐ Seating accommodations for obesity

Will a seatbelt extension be required? ○ Yes ○ No

Height (cm) _____ Weight (kg)_____

Waist(cm) _____ Hips (cm)_____

Other seating accommodation explanation

_____

_____

☐ Assistance requirements Please indicate if your patient requires any of the following:

☐ Aid taking medication

☐ Aid using the lavatory (once inside)

☐ Aid managing meals

Details _____

Other Please provide any final details you feel relevant to your patient's situation or accommodation request:

_____

_____

_____

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Signature (physician) _____ Date MM/DD/YYY_____