THAI

Thai Airways international Public Company Limited

MEDIF

PART 1 To be completed by SALES OFFICE/AGENT	**INCAPACITATED PASSENGERS HANDLING ADVICE (INCAD)** **HANDLING INFORMATION - PART 1** **Answer ALL questions - put a cross (x) in "YES" or "NO" boxes.** **Use BLOCK LETTERS or TYPEWRITER when completing this form.**	**Category**

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)

1st Flight No. : TG …… From: ……To: ……
Date: …… PNR: ……

2nd Flight No. : TG …… From: ……To: ……
Date: …… PNR: ……

Transfer from one flight to another often requires LONGER connecting time (Minimum Connecting Time must be at least two hours.)

C NATURE OF INCAPACITATION / ILLNESS:

MEDICAL CLEARANCE REQUIRED? ☐ No ☐ Yes

D IS STRETCHER NEEDED ON BOARD? (all stretcher cases MUST be escorted.)

☐ No ☐ Yes

Request rate if unknown

E INTENDED ESCORT (name, sex, age, professional qualification, 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: ……

For blind and/or deaf, state if escorted by trained dog.

F WHEELCHAIR NEEDED? ☐ No ☐ Yes

Categories are *WCHR *WCHS *WCHC Wheelchair Category:

☐ WCHR ☐ WCHS ☐ WCHC	Own wheelchair	Collapsible	Power driven?	Battery Type (spillable?)
	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

Wheelchair with spillable batteries are "restricted articles' and are permitted on passenger aircraft only under certain conditions, which can be obtained from the airlines (s). In addition, certain countries may impose specific. restrictions.

G AMBULANCE NEEDED? ☐ No ☐ Yes

To be arranged by PHYSICIAN AND/OR PATIENT
☐ No ☐ Yes
Specify ambulance company contact:
Specify destination address:

Request rate (s) if unknown

H OTHER GROUND ARRANGEMENTS NEEDED ☐ No ☐ Yes

If yes, SPECIFY below and indicate for each item:
(a) the ARRANGING airline or other organisation,
(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	☐ No ☐ Yes	Specify:	
H2	Arrangement for assistance at CONNECTING POINTS	☐ No ☐ Yes	Specify:	
H3	Arrangement for meeting at airport of ARRIVAL	☐ No ☐ Yes	Specify:	
H4	Other requirements or relevant information	☐ No ☐ Yes	Specify:	

K 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) ☐ No ☐ 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.

L DOES PASSENGER HOLD A "FREQUENT TRAVELLER'S MEDICAL CARD" VALID FOR THIS TRIP? (FREMEC) ☐ No ☐ Yes

If yes, add below FREMEC date to your reservation requests.
If no (or if additional data needed by carrying airline (s)).
Have physician in attendance complete PART 2 hereof.

FREMEC /					
(FREMEC Number)	(Issued by)	(Valid until)	(Sex)	(Age)	(Incapacitation)

(Incapacitation continued) (Limitations)

*WCHR = passenger cannot walk well, but can use stairs, *WCHS = passenger cannot going up and down stairs, *WCHC = passenger cannot walk at all.

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PART 2	MEDICAL INFORMATION FORM - MEDIF	For official use only
To be completed by **ATTENDING PHYSICIAN**	**This form is intended to provide CONFIDENTIAL information to enable the airlines 'MEDICAL Departments 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.** **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.** **IN CASE OF HIV POSITIVE PATIENT, THE LATEST CHEST X-RAY RESULT SHOULD BE ATTACHED TO THIS MEDICAL INFORMATION FORM.** **COMPLETING OF THE FORM IN BLOCK LETTERS OR BY TYPEWRITER WILL BE APPRECIATED.**	**Please return the completed form to** **ADDRESS of TG Issuing Office**

MEDA01	PATIENT'S NAME, INITIAL(S), SEX, AGE						
MEDA02	ATTENDING PHYSICIAN - Name & Address - Telephone Contact	Name:		Address:			
		Business:		Home:			
MEDA03	MEDICAL DATA: - DIAGNOSIS and TREATMENT in details						
	- Latest vital signs:	BP= /	PR=	RR=	TEMP=	Spo2=	Date
	- Day/month/year of first symptoms:			Date of diagnosis:			
MEDA04	PROGNOSIS for the flight (s):	☐ GOOD (No problem Anticipated)		☐ GUARDED (Potential Problems)		☐ POOR (Problems Likely)	
MEDA05	- Contagious AND communicable disease?	☐ No	☐ Yes	Specify:			
MEDA06	- Would the physician and/or mental condition of the patient be likely to cause distress or discomfort to other passengers?	☐ No	☐ Yes	Specify:			
MEDA07	- Can patient use normal aircraft seat with seatback placed in the UPRIGHT position when so required?	☐ No	☐ Yes				
MEDA08	- Can patient take care of his own needs on board UNASSISTED * (INCLUDING meals, visit to toilet, etc) ?	☐ No	☐ Yes				
		If not, type of help needed					
MEDA09	- If to be ESCORTED, is the arrangement satisfactory to you?	☐ Yes	☐ No				
		If not, type of escort proposed by YOU					
MEDA10	- Does patient need OXYGEN ** equipment in flight? (If yes, state rate of flow).	☐ No	☐ Yes	Litres per minute _____	Continuous	☐ No	☐ 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):					
		☐ No	☐ Yes	Specify:			
MEDA12		(b) on board of the AIRCRAFT:					
		☐ No	☐ 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 patient is responsible for all arrangement.	(a) during long layover or nightstop at CONNECTING POINTS en route:					
		☐ No	☐ Yes	Action:			
MEDA14		(b) upon arrival at DESTINATION:					
		☐ No	☐ Yes	Action:			
MEDA15	- Other remarks or information in the interest of your patient's smooth and comfortable transportation.	☐ None	Specify if any**				
MEDA16	- Other arrangements made by the attending physician.						
NOTE(*):	Cabin attendants are NOT authorized to give special asistance 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 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:**

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PART 3		**MEDICAL INFORMATION FORM - MEDIF**		
To be completed by **Attending Physician**		**This is for transportation purposes only. We, the Aero Medical Center of THAI AIRWAYS, 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:	Male / Female Height(cm): Weight (kg):
3.2	A. Mental status	☐ Alert ☐ Drowsy ☐ Stupor ☐ Semi-coma ☐ Coma	**GCS Score:** E V M	
		Pupil size _____/_____ mm (☐ react ☐ sluggish ☐ not react)		
	B. Physical examination	Respiratory		
		Cardiovascular		
		Neurological		
	C. Underlying disease	☐ Yes ☐ No	If yes, (Please specify)	
	D. Hospitalization operation/Procedure	Did this patient have surgery / Medical procedure? If yes, name of operation / procedure	☐ Yes ☐ No	
		Is there any complication after surgery / procedure? If yes, please explain	☐ Yes ☐ No	
		Has/Had this patient been admitted to the hospital recently?	☐ Yes ☐ No	
		If yes, where? ☐ ICU ☐ General ward ☐ ER ☐ Other (please specify)		
		Hospitalization date:	Discharge date:	
3.3	Medication	Does this patient take any medications?	☐ Yes ☐ No	
		If yes, ☐ Orally ☐ IV or IM ☐ 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	☐ None ☐ IV line ☐ Foley catheter ☐ Nasogastric tube ☐ Chest tube ☐ Endotracheal tube ☐ Tracheostomy ☐ Suction kit ☐ Oxymeter ☐ Infusion pump ☐ Nebulizer ☐ Portable oxygen concentrator ☐ Ventilator (Setting: _____) Brand and Model: _____ ☐ Splint/Cast ☐ Other		
		* In case of medical equipment use, please notice the equipment model type to THAI AIRWAYS reservation center. * Any necessary supply of electricity should be from battery power only. * IV fluid should be prepared in plastic bag.		
***NOTE* * Please attached OFFICIAL medical summary or currently medical report, FIT to FLY certificate and test result. (Blood test or Image test, etc.) related the patient's disease with hospital stamp.**				
Available contact number:		Date:	Attending Physician signature: (Hospital Stamp)	
THAI AIRWAYS		☐ APPROVED ☐ REJECTED ☐ NEED DETAILS **Remark:**		
PHYSICIAN APPROVAL		**TG Medical Approval (_____)**		

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PART 4 To be completed by **PATIENT**	**INDEMNITY FORM - MEDIF**	
PASSENGER'S DECLARATION	PASSENGER'S DECLARATION "I HEREBY AUTHORIZE…… (Name of nominated physician) 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 thereof I hereby relieve that physician of his/her professional duty of confidentiality in respect of such information, and agree to meet such physician's fees in connection therewith. 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. 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. 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, deportation or quarantine costs etc.) incurred. 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. 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, their physician, employees, servants and agents from any liability for such consequences. I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AGREE TO THEM FULLY (Where needed, to be read by/to the passenger, dated and signed by him/her, or on his/her behalf)	
Place:	**Date:**	**Passenger's Signature:**