



MEDIF

Information Sheet for Passengers Requiring Special Assistance

Confidential
Part 1 of 3
 To be completed by the Passenger and/or the Passenger's Physician in consultation with SIA Sales Office/ Travel Agent

Answer ALL questions. Tick in 'Yes' or 'No' boxes.
 Use BLOCK LETTERS or TYPEWRITER when completing this form.

A	NAME/INITIALS/TITLE:	
B	PROPOSED ITINERARY (Airline(s), flight number(s), class(es), date(s), segment(s) and reservation status of continuous air journey)	Transfer from one flight to another often requires LONGER connecting time

C	NATURE OF MEDICAL CONDITION:	Medical clearance required? <input type="checkbox"/> No <input type="checkbox"/> Yes
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D	IS STRETCHER NEEDED ON BOARD? (All stretcher cases MUST be escorted)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Request rate if unknown
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E	INTENDED ESCORT (name, gender, age, professional qualification, segments, if different from passenger) If your escort is untrained, state 'TRAVEL COMPANION'.	Escorted by trained assistance dog? <input type="checkbox"/> No <input type="checkbox"/> Yes
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F	Wheelchair needed? <input type="checkbox"/> No <input type="checkbox"/> Yes Categories are: WCHR, WCHS, WCHC Wheelchair category:	<table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <tr> <td>OWN Wheelchair?</td> <td>Collapsible?</td> <td>Power driven?</td> <td>Battery type (spillable)?</td> </tr> <tr> <td><input type="checkbox"/> No <input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No <input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No <input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> </table>	OWN Wheelchair?	Collapsible?	Power driven?	Battery type (spillable)?	<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	Wheelchairs with spillable batteries are 'dangerous goods' 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 restrictions.
OWN Wheelchair?	Collapsible?	Power driven?	Battery type (spillable)?								
<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 SPONSOR <input type="checkbox"/> No Specify Ambulance Company contact: _____ <input type="checkbox"/> Yes Specify destination address: _____	Request rate(s) if unknown.
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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 organisation, (b) at whose EXPENSE, and (c) CONTACT addresses/telephone numbers where appropriate, or whenever specific persons are designated to meet/assist the passenger.
1	Arrangements for delivery at airport of DEPARTURE	<input type="checkbox"/> No <input type="checkbox"/> Yes	Specify:	_____
2	Arrangements for assistance at CONNECTING POINTS:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Specify:	_____
3	Arrangements for meeting at airport of ARRIVAL	<input type="checkbox"/> No <input type="checkbox"/> Yes	Specify:	_____
4	Other requirements or relevant information	<input type="checkbox"/> No <input type="checkbox"/> Yes	Specify:	_____

K	SPECIAL IN-FLIGHT ARRANGEMENTS NEEDED, such as: special meals, special seating, leg-rest, extra seat (s), special equipment etc.	<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.
	(See 'Note (*)' at the end of Part 2 overleaf)		_____

ALL MEDICAL CASES MUST NOT BE ASSIGNED EMERGENCY EXIT SEATS

PASSENGER'S DECLARATION

"I HEREBY AUTHORISE _____ (Name of nominated)

to provide the airlines with the information required by those airlines' medical department 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(s) concerned and that the carrier(s) do not assume any special liability exceeding those conditions/tariffs.

I agree to reimburse the carrier(s) upon demand for any special expenditures or costs in connection with my carriage. (Where needed, to be read by/to the passenger, dated and signed by him/her, or on his/her behalf)"

I agree that the personal and medical details provided in this form will be processed by Singapore Airlines to handle my request for special assistance. Further, in order to assess and manage my request, and in order to arrange for the appropriate assistance, care and equipment, I acknowledge that it is necessary for Singapore Airlines to process and/or disclose my personal and/or medical information to other airlines and to third parties, such as medical professionals, airport and airline staff, government bodies and border control authorities.

For more information, please refer to SIA's Privacy Policy which may be found at https://www.singaporeair.com/en_UK/privacy-policy/

I hereby consent to my personal and/or medical data being processed, used and/or disclosed for the purposes set out above.

Place:	Date:	Passenger's Signature:
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MEDIF

Standard Medical Information Form for Air Travel

CONFIDENTIAL

Part 2 of 3
(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 as indicated in Part 1 overleaf. 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 passenger is requested to **ANSWER ALL QUESTIONS**. (Enter a tick in the appropriate 'yes' or 'no' boxes, and/or give precise concise answers).

This form must be returned to

(Carrier's Designated Office)

Airlines' Ref Code MEDA 01	PATIENT'S NAME, INITIAL(S), SEX, AGE:				
MEDA 02	ATTENDING PHYSICIAN - Name & Address				
	- Telephone Contact	Business:	Home:		
	- Relationship to Passenger	(If any)			
MEDA 03	MEDICAL DATA: - DIAGNOSIS in details (including vital signs)				
	- Day/month/year of first symptoms:	Date of operation:	Date of diagnosis:		
MEDA 04	PROGNOSIS for the flight(s): Taking into account Part1, Section B	Fit to Travel	Not Fit to Travel	Specify:	
MEDA 05	Contagious AND communicable disease?	No	Yes	Specify:	
MEDA 06	Would the physical and/or mental condition of the patient be likely to cause distress or discomfort to other passengers?	No	Yes	Specify:	
MEDA 07	Can the patient use normal aircraft seat with the seatback placed in the UPRIGHT position when so required?	Yes	No		
MEDA 08	Can the patient take care of his own needs on board UNASSISTED * (including meals, visit to toilet, etc)?	Yes	No		
		If not, type of help needed:			
MEDA 09	If to be ESCORTED, is the arrangement proposed in part 1/E overleaf satisfactory for you?	Yes	No		
		If not, type of escort proposed by YOU:			
MEDA 10	Does patient need OXYGEN ** equipment in flight? (if yes, state rate of flow)	No	Yes	2 / 4 Litres per minute (Pls circle the applicable)	No Yes Continuous?
MEDA 11	Does patient need any MEDICATION *, other than self-administered, and/or the use of special apparatus such as respirator, incubator, POC etc. (**)? And how critical these apparatus?	(a) on the GROUND while at the airport(s):			
		No	Yes	Specify:	
MEDA 12		(b) on BOARD the aircraft:			
		No	Yes	Specify:	
MEDA 13	Does patient need HOSPITALISATION? (If yes, indicate arrangements made or, if none were made, indicate 'NO ACTION TAKEN')	(a) during long layover or nightstop at CONNECTING POINTS en route:			
		No	Yes	Action:	
MEDA 14		(b) upon arrival at DESTINATION:			
		No	Yes	Action:	
MEDA 15	Other remarks or information in the interest of your patient's smooth and comfortable transportation:	None	Specify if any **		
MEDA 16	Other arrangements made by the attending physician:				

NOTE (*): Cabin attendants are NOT authorized to give special assistance (e.g. lifting) 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.

Date:	Place:	Attending Physician's Signature and Stamp:
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MEDIF
Standard Medical Information Form for Air Travel

CONFIDENTIAL

Part 3 of 3

NOTES FOR THE GUIDANCE OF MEDICAL PRACTITIONERS

The principal factors to be considered when assessing a patient's fitness for air travel are the effects of reduced atmospheric pressure and consequent reduction in oxygen tension. Even in pressurized aircraft, the cabin may be at a pressure equivalent to an altitude of 5,000 to 7,000 feet.

In cases of doubt or for further information, Medical Practitioners should consult the SIA Medical Officer or refer to the passenger travel guidelines issued by SIA. The relevant contact details can be obtained from any SIA office.

Any information given by SIA and/or its Medical Advisors is strictly for the purpose of clarifying the conditions onboard the pressurized Aircraft. Any and all clarifications that have been communicated do not affect the Attending Physician's independent prognosis or assessment of the patient's fitness to travel.

SIA MEDICAL DEPARTMENT USE

CONCUR with Assessment of Attending Doctor

DO NOT CONCUR with Assessment of Attending Doctor

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SIA Doctor Signature

Name of SIA Doctor

Clinic/Hospital Stamp

Passenger Name & Passport Number

Remarks

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