



# HANDLING ADVICE/INVALID PASSENGER

**To be issued for all passengers:**

- with injuries of the skull/brains, with internal or large-external injuries (wounds, burns)
- with multiple sklerosis
- with a spasmodic paralysis with cerebral damage
- with a mental deficiency
- whose intended date of travel is earlier than 6 months after a heart infarct or a stroke
- who are dependent during flight on special equipment or treatment (oxygen, respirator, incubator, infusions etc.)
- who cannot travel on a passenger seat with backrest in upright position (carriage on stretcher)

**MEDA**

**A** PASSENGER'S NAME ..... SEX ..... AGE ..... TEL. NO. ....

**B** ROUTING FROM ..... TO ..... FLIGHT N. .... CLASS ..... DATE .....

**C** DIAGNOSIS .....

**ESCORT FOR THE JOURNEY REQUIRED**

**D**  NO  YES, BY A PHYSICIAN (name) .....  YES, BY ANY OTHER QUALIFIED PERSON (name) .....

**REQUIRED ASSISTANCE:**

- E**
- WCHR** Ambulant but impaired in walking. Needs assistance in terminal to/from gate, needs wheelchair or similar when passengers are boarded/deplaned by walking over ramp. Does not need assistance in a ramp bus, on passenger steps and in the aircraft cabin to/from seat, toilets and with meals.
  - WCHS** Ambulant but more severely limited in walking: cannot use a ramp bus and needs assistance in boarding/deplaning (e.g. on passenger steps). Does not need assistance in the aircraft cabin to/from seat, toilets and possibly with meals.
  - WCHS/OWN** As above - accompanied by own wheelchair. Add "BD" if battery-driven wheelchair.
  - WCHC** Non-ambulant. Needs also assistance in the aircraft cabin to/from seat, toilets.
  - WCHC/OWN** As above - accompanied by own wheelchair. Add "BD" if battery-driven wheelchair.
  - BED** Must travel on a stretcher.

**AT DESTINATION PATIENT WILL BE TAKEN TO A HOSPITAL**  NO  YES

**F** Name and address of hospital .....

**AMBULANCE** Designated ambulance to be arranged at destination by the passenger himself or by any other specialized company, at passengers expenses.

**OXYGEN OCCASIONAL** Needs occasional oxygen supply during flight.

**OXYGEN CONTINUOUS** Needs continuous oxygen supply during flight.

**G**  **OTHER** Other ground and/or in-flight arrangements needed and/or arrangements made by attending physician. Specify.

**H** **FREMEC issued by Airline** ..... **Valid until** .....

**Date** ..... **Name of attending physician** ..... **Signature of attending physician** .....

**PASSENGER'S DECLARATION**

I hereby authorize \_\_\_\_\_ (name of the attending physician) to disclose Air Dolomiti the necessary information on my condition of health and I herewith relieve the attending physician of his/her professional duty of confidentiality in respect of such information. The undersigned will also indemnify and release Air Dolomiti, their representatives and agents from any liability for damage sustained in connection with the deterioration of his/her illness as a result of this transportation by air. In case of a legal dispute, the undersigned will have to prove that any of such damage was caused by Air Dolomiti, or third parties through that specific air transportation. The undersigned also declares to be informed that Air Dolomiti is not obligated in any way to accept him/her for any subsequent or return journey. Otherwise, the Conditions of Carriage, in particular the rules of liability contained therein, will apply.

**Date** ..... **Issuing office** ..... **Passenger's name** .....

**PASSENGER'S signature**



# MEDICAL INFORMATION BY ATTENDING PHYSICIAN

**Note for the attending physician:**

The details requested in here will be treated confidentially. They should enable the Airline Company to determine if the patient can be permitted and under what conditions to travel by aircraft as requested. The attending physician is kindly requested to answer all questions by cross or in block letters, as necessary. Thank you.

MEDA 01	<b>PATIENT'S NAME/ADDRESS</b>	<b>SEX</b>	<b>AGE</b>
MEDA 02	<b>NAME/ADDRESS OF ATTENDING PHYSICIAN</b>	<b>TEL. BUSINESS</b>	<b>TEL. HOME</b>
MEDA 03	<b>MEDICAL DATA: DIAGNOSIS (details including vital signs)</b>		
	<b>DAY/MONTH/YEAR OF FIRST SYMPTOMS</b>	<b>DATE OF DIAGNOSIS</b>	
MEDA 04	<b>PROGNOSIS FOR THE TRIP</b>		
MEDA 05	Contagious and communicable disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Specify .....
MEDA 06	NIL .....		
MEDA 07	Can patient use normal aircraft seat with seatback placed in the upright position?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
MEDA 08	Can patient take care of his own needs on board unassisted (including meals, visit to toilet, etc.)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If not, type of help needed .....
MEDA 09	Shall passenger be escorted?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, type of escort proposed by the physician .....
MEDA 10	Does patient need oxygen during flight?	<input type="checkbox"/> YES <input type="checkbox"/> NO	.....
	Rate of flow/Lit. per minute _____ Continuous?	<input type="checkbox"/> YES <input type="checkbox"/> NO	.....
MEDA 11	Does patient need any medication, other than self administered, and/or the use of special apparatus such as respirator, incubator, etc.?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Specify .....
MEDA 12	On the ground while at the airport?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Specify .....
	On board the aircraft?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Specify .....
MEDA 13 MEDA 14	Does patient need hospitalisation?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, indicate arrangements made or, if none were made indicate, "No action taken" .....
	During long layover or nightstop at connecting points enroute Upon arrival at destination	<input type="checkbox"/> YES <input type="checkbox"/> NO	Action .....
MEDA 15	Other remarks or information in the interest of your patient's smooth and comfortable transportation	<input type="checkbox"/> NONE	Specify if any .....
MEDA 16	Other arrangements made by the attending physician .....		

**ATTENDING PHYSICIAN'S DECLARATION**

I certify that the above mentioned patient can and is permitted to travel by aircraft with the flight specified in the part MEDA B, as long as the special circumstances specified by myself in this part are observed.

Date ..... Place .....

**ATTENDING PHYSICIAN'S SIGNATURE**