

 SINGAPORE AIRLINES	MEDIF Information Sheet for Passengers Requiring Special Assistance Answer ALL questions. Put a cross (X) in 'Yes' or 'No' boxes. Use BLOCK LETTERS or TYPEWRITER when completing this form.	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																
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 INCAPACITATION: _____ Medical clearance required? No ☐ Yes ☐																	
D	IS STRETCHER NEEDED ON BOARD? No ☐ Yes ☐ (All stretcher cases MUST be escorted) Request rate if unknown																	
E	INTENDED ESCORT (name, gender, age, professional qualification, segments, if different from passenger) If untrained, state 'TRAVEL COMPANION'.	For customer who is visually handicapped and/or hearing impaired if escorted by trained dog.																
F	Wheelchair needed? No ☐ Yes ☐ Categories are: WCHR, WCHS, WCHC Wheelchair category: _____ <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: center;">OWN Wheelchair?</th> <th style="text-align: center;">Collapsible</th> <th style="text-align: center;">Power driven?</th> <th style="text-align: center;">Battery type (spillable)?</th> </tr> <tr> <td>No ☐ Yes ☐</td> <td>No ☐ Yes ☐</td> <td>No ☐ Yes ☐</td> <td>No ☐ Yes ☐</td> </tr> </table> 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)?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐								
OWN Wheelchair?	Collapsible	Power driven?	Battery type (spillable)?															
No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐															
G	Ambulance needed? No ☐ Yes ☐ To be arranged by SPONSOR 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/telephone numbers where appropriate, or whenever specific persons are designated to meet/assist the passenger. <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">1</td> <td style="width: 20%;">Arrangements for delivery at airport of DEPARTURE</td> <td style="width: 10%;">No ☐ Yes ☐</td> <td style="width: 10%;">Specify: _____</td> </tr> <tr> <td style="text-align: center;">2</td> <td>Arrangements for assistance at CONNECTING POINTS:</td> <td>No ☐ Yes ☐</td> <td>Specify: _____</td> </tr> <tr> <td style="text-align: center;">3</td> <td>Arrangements for meeting at airport of ARRIVAL</td> <td>No ☐ Yes ☐</td> <td>Specify: _____</td> </tr> <tr> <td style="text-align: center;">4</td> <td>Other requirements or relevant information</td> <td>No ☐ Yes ☐</td> <td>Specify: _____</td> </tr> </table>		1	Arrangements for delivery at airport of DEPARTURE	No ☐ Yes ☐	Specify: _____	2	Arrangements for assistance at CONNECTING POINTS:	No ☐ Yes ☐	Specify: _____	3	Arrangements for meeting at airport of ARRIVAL	No ☐ Yes ☐	Specify: _____	4	Other requirements or relevant information	No ☐ Yes ☐	Specify: _____
1	Arrangements for delivery at airport of DEPARTURE	No ☐ Yes ☐	Specify: _____															
2	Arrangements for assistance at CONNECTING POINTS:	No ☐ Yes ☐	Specify: _____															
3	Arrangements for meeting at airport of ARRIVAL	No ☐ Yes ☐	Specify: _____															
4	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. 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. (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 physician) 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)"																		
Place:	Date:	Passenger's Signature:																

		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 incapacitated passenger is requested to ANSWER ALL QUESTIONS. (Enter a cross 'X' 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	(a) on the GROUND while at the airport(s): Does patient need any MEDICATION *, other than self-administered, and/or the use of special apparatus such as respirator, incubator etc. * * ? And how critical these apparatus? No ☐ Yes ☐ Specify:				
MEDA 12	(b) on BOARD the aircraft: Does patient need any MEDICATION *, other than self-administered, and/or the use of special apparatus such as respirator, incubator etc. * * ? And how critical these apparatus? No ☐ Yes ☐ Specify:				
MEDA 13	(a) during long layover or nightstop at CONNECTING POINTS en route: Does patient need HOSPITALISATION? (If yes, indicate arrangements made or, if none were made, indicate 'NO ACTION TAKEN') No ☐ Yes ☐ Action:				
MEDA 14	(b) upon arrival at DESTINATION: Does patient need HOSPITALISATION? (If yes, indicate arrangements made or, if none were made, indicate 'NO ACTION TAKEN') 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:	



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

Name of SIA Doctor

Clinic/Hospital Stamp

Passenger Name & Passport Number

Remarks

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