ANGEL FLIGHT EAST

Hope in Flight …

MEDICAL APPROVAL FORM

This form must be completed and signed by the patient's physician before a mission can be flown with Angel Flight East (AFE). PLEASE FAX THE COMPLETED FORM BACK TO OUR OFFICE AT ***(215) 358-1999*** **or scan and email to: missions@angelflighteast.org.**

Information the physician should know before completing this form:

1. There is no medical equipment or personnel on board unless provided by the patient.
2. Planes used for patient missions are privately owned or rented by the pilot. They are single or twin-engine planes that accommodate 4 or 6 passengers including the pilot. There may be no restrooms. There is not sufficient room for the patient to recline or move about.
3. Patients must be ambulatory and mobile enough to board and disembark. Boarding will require a high step of 18-20 inches. If a low-wing aircraft is used, the patient would also be taking several steps on the wing of the plane. Passengers have to bend over to enter and exit the plane.
4. The vast majority of the planes are not pressurized. In a non-pressurized plane, the passengers are breathing the air at the altitude they are flying
5. Generally, the planes fly at an altitude below 10,000 feet, but there may be exceptions to this.
6. If turbulence is encountered, the patient will experience more bumpiness than on a commercial aircraft. Flight times are much longer than in a commercial aircraft. An average cruising speed is approximately 140 miles an hour, but varies with different types of planes.
7. The patient may take a support person along on the flight for assistance.

By signing this form, you are giving your approval, based on the patient's medical conditions and medical history known to me at this time that it is reasonably safe for the patient to fly under such conditions as described above.

A. Patient's name: _____ Patient's Weight_____ lbs.

B. Physician's name: _____

C. Physician's phone #: _____ On-call #: _____

D. Facility/Agency requesting transportation: _____

Address: _____

City: _____ State: _____ Zip: _____

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E. Person responsible for transportation arrangements: (other than doctor)

Name: _____ Phone #: _____

F. Facility at which the patient will be receiving treatment:

Name: _____

G. What is the patient's principal diagnosis? If the patient is being treated for a different diagnosis please specify.

H. Does patient currently have a contagious or communicable disease? ___**YES** ____**NO**
Please explain:

I. In layman's terms, describe the specific medical purpose for this trip:

J. If treatment for the patient requires a series of flights over a period of time, is the patient's condition expected to remain stable during this time? ___**YES** ___**NO**
Comments:

K. Is it medically safe for the patient to fly in a small, light, "non-pressurized" aircraft?
___ **YES** ___**NO**
Comments:

L. Is the patient able to walk and get in and out of the aircraft unassisted? (Boarding may require a high Step of 18-20 inches or several steps on the wing of the plane. Passengers have to bend over to enter and exit plane.) _____**YES** _____**NO**
Comments:

M. Is there any other information that you feel might be helpful for the pilot to know about this patient? _____ YES _____NO Comments:

I have carefully read and completed the above information and approve this patient for flight in a non-pressurized, light aircraft.

Physician's Signature_____ **Date**_____

_____
Print Physician's Name

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