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Thai Airways international Public Company Limited

**MEDIF**

| **PART 1**<br>To be completed<br>by<br>SALES OFFICE/AGENT | **INCAPACITATED PASSENGERS HANDLING ADVICE (INCAD)**<br>**HANDLING INFORMATION - PART 1**<br>**Answer ALL questions - put a cross (x) in "YES" or "NO" boxes.**<br>**Use BLOCK LETTERS or TYPEWRITER when completing this form.** | **Category** |
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| | | | |
|---|---|---|---|
| A | NAME / INITIALS / TITLE<br>Last name : ……First name : ……Title : …… Age : …… | | |
| B | PROPOSED ITINERARY<br>(airline (s), flight number (s),<br>class (es), date (s), segment (s),<br>reservation status of continuous<br>air journey) | 1st Flight No. : TG …… From: ……To: ……<br>Date: …… PNR: ……<br><br>2nd Flight No. : TG …… From: ……To: ……<br>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?<br>(all stretcher cases MUST be escorted.) | ☐ No ☐ Yes | Request rate if unknown |
| E | INTENDED ESCORT (name, sex, age,<br>professional qualification, segments<br>if different from passenger) | Last name: …… First name: ……<br>Sex: …… Age: …… Doctor / Nurse / Paramedic/ Other<br>PNR: ……<br><br>Last name: …… First name: ……<br>Sex: …… Age: …… Doctor / Nurse / Paramedic/ Other<br>PNR: …… | For blind and/or deaf,<br>state if escorted by trained dog. |

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| F | WHEELCHAIR NEEDED? ☐ No ☐ Yes<br><br>Categories are<br>*WCHR *WCHS *WCHC<br>Wheelchair Category: | Own wheelchair | Collapsible | Power driven? | Battery Type (spillable?) | 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. |
| | ☐ WCHR<br>☐ WCHS<br>☐ WCHC | ☐ No<br>☐ Yes | ☐ No<br>☐ Yes | ☐ No<br>☐ Yes | ☐ No<br>☐ Yes | |

| | | | |
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| G | AMBULANCE NEEDED? ☐ No ☐ Yes | To be arranged by PHYSICIAN AND/OR PATIENT | |
| | | Specify ambulance company contact: | |
| | | Specify destination address: | |

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| H | OTHER GROUND ARRANGEMENTS NEEDED ☐ No ☐ Yes | If yes, SPECIFY below and indicate for each item:<br>(a) the ARRANGING airline or other organisation,<br>(b) at whose EXPENSE, and<br>(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: | |

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| I | SPECIAL IN-FLIGHT ARRANGEMENTS NEEDED such as: special meals, special seating, leg-rest, extra seat (s), special equipment, etc.<br>(See Note* at the end of PART 2 overleaf) | ☐ No ☐ Yes | If yes, DESCRIBE and indicate for each item:<br>(a) SEGMENT (s) on which required,<br>(b) airline-ARRANGED or arranging third party, and<br>(c) at whose expense.<br>Provision of SPECIAL EQUIPMENT such as oxygen etc., always requires completion of PART 2 overleaf. |

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| J | 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.<br>If no (or if additional data needed by carrying airline (s)).<br>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 |
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| 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.**<br><br>**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.**<br><br>**IN CASE OF HIV POSITIVE PATIENT, THE LATEST CHEST X-RAY RESULT SHOULD BE ATTACHED TO THIS MEDICAL INFORMATION FORM.**<br><br>**COMPLETING OF THE FORM IN BLOCK LETTERS OR BY TYPEWRITER WILL BE APPRECIATED.** | **Please return the completed form to**<br><br>**ADDRESS of TG Issuing Office** |

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| MEDA01 | PATIENT'S NAME, INITIAL(S), SEX, AGE | | | | | | |
| MEDA02 | ATTENDING PHYSICIAN<br>- Name & Address<br>- Telephone Contact | Name: Address:<br>Business: Home: | | | | | |
| MEDA03 | MEDICAL DATA:<br>- 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 | - Does the patient fit to travel unescorted? | ☐ Yes ☐ No | | | | | |
| | | If not, who should escort the patient | ☐ Doctor ☐ Nurse ☐ Paramedic ☐ Other | | | | |
| 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.** | | | | | |
| 1 | Patient | Name: | | Age: | Male / Female | Height(cm): | Weight (kg): |
| 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 | 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? | | | | | |
| 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.<br>* Any necessary supply of electricity should be from battery power only.<br>* 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) | | | |

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| **PART 4**<br>To be completed by **PATIENT** | **INDEMNITY FORM - MEDIF** | |
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| **PASSENGER'S DECLARATION** | PASSENGER'S DECLARATION<br>"I HEREBY AUTHORIZE.....<br>(Name of nominated physician)<br><br>to provide the airline with the information required by the airline's 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.<br><br>I take note that, if accepted for carriage, my journey will be subject to the general conditions of carriage/tariffs of the airline concerned and that the airline does not assume any special liability exceeding those conditions/tariffs.<br><br>In the event of sudden change of my medical condition prior to the journey, I agree to notify the airline and to submit the updated medical information/medical report or MEDIF to the airline to prevent unforeseen in-flight medical events.<br><br>I, the undersigned will indemnify and release the airline 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.<br><br>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.<br><br>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 airline, its physician, employees, servants and agents from any liability for such consequences.<br><br>**I explicitly consent to the processing of my medical information under airline's privacy notice, including the transfer of this information to the third parties where required.**<br><br>I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AGREE TO THEM FULLY<br>(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:** ** |

**Pls fill in the form with the mark