

**MEDICAL INFORMATION FORM (MEDIF)**
**[To be completed by the attending physician]**

The attending physician is requested to answer all questions. Enter a check mark (✓) in the appropriate "Yes" or "No" boxes, and/or give precise and concise answers. Please submit the Medical Information Form by document submission form or fax at least 3 days before departure.

 •Files Submission Form : <https://cs.flypeach.com/hc/en-us/articles/4659128875294>

•FAX : +81-50-3737-9665

**PATIENTS INFORMATION**

Name		Age	
		Gender	<input type="checkbox"/> male <input type="checkbox"/> female
Diagnosis in details	*Please write so that non medical personnel can understand.		
When did the first symptoms appear (Date of Operations, if any)	Date:	For expecting mother (Estimated delivery date)	Date:

**DIAGNOSIS CONTENT**

1	Prognosis for the flight(s)	1 : Date _____ <input type="checkbox"/> Fit <input type="checkbox"/> Not Fit 2 : Date _____ <input type="checkbox"/> Fit <input type="checkbox"/> Not Fit
2	Can the patient use normal aircraft seat with the seatback placed in the Upright Position when so required? (during take-off and landing)	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Can the patient is fully capable/able to use lavatory, provide self-care (eat, drink...etc.) unattended without assistant from flight crew?	<input type="checkbox"/> Yes (*The patient must be fully knowledgeable in its use.) <input type="checkbox"/> No, Must be accompanied by Physician or Nurse <input type="checkbox"/> No, Must be accompanied by a person who is approved by Physician Escort name [ _____ ]
4	Dose passenger need Oxygen equipment in flight?	<input type="checkbox"/> Yes → If "Yes",Liters per minute : <input type="text"/> (ℓ/min) <input type="checkbox"/> No
	Continuous use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Dose the patient need medical equipment in flight?	<input type="checkbox"/> Yes → <The Name of Medical Equipment> _____
		<input type="checkbox"/> No <Manufacturer or Distributor> _____
		<Product name / type or model number> _____
		<Size / Type of Battery> _____
6	Does patient need any medication in flight?	<input type="checkbox"/> Yes → Specify: <input type="checkbox"/> No
7	Specify more details, if necessary	

Prognosis as above. I will provide necessary information required by the airline's for the purpose of determining his/her fitness to travel by air with consent of the patient.

<b>PHYSICIAN</b>		Date of Submission:	
NAME (Signature)			
Hospital Name			
Telephone Number		Emergency Telephone Number	

**SPECIAL ASSISTANCE REQUEST**

[To be completed by the passenger or travel agent]

**PATIENTS INFORMATION**

Name		Age	
		Gender	<input type="checkbox"/> male <input type="checkbox"/> female
Telephone Number	(Home)	(Mobile)	
E-mail Address			
Itinerary	1.Date:	Flight No.:	Travel segment(DEP-ARR): ( — )
	2.Date:	Flight No.:	Travel segment(DEP-ARR): ( — )
Personal Escort	Name:	<input type="checkbox"/> Pysician <input type="checkbox"/> Nurse <input type="checkbox"/> Others ( _____ )	
Personal Escort	Name:	<input type="checkbox"/> Pysician <input type="checkbox"/> Nurse <input type="checkbox"/> Others ( _____ )	

1 Do you need wheelchair?  No  Yes → Please let us know your mobility condition in order for us to accommodate your needs

Unable to walk, require wheelchair at all time

Able to walk but require assistant ascend or descend steps

Able ascend or descend steps by own accord but unable walk long distance

2 Please tell us about your personal mobility assistant device, wheelchair.

No wheelchair

Personal wheelchair →  Manual →  Foldable  Non-Foldabl

Electric/Battery-powered →  Li-ion Battery  Dry Battery (NiCad, Ni-MH)  Non-Spillable Battery (Wet-cell "sealed")  Spillable Battery (Wet-cell "non-sealed")

\*Please send "Wheelchair Check Form" if you require wheelchair assistant.

3 Do you require wheelchair in cabin?  No  Yes

4 Do you require Oxygen Cylinder in flight?  No  Yes → If yes, please send "Oxygen Cylinder Check Form".

5 Do you use Portable Oxygen Concentrator in flight?  No  Yes → If yes, please send "Oxygen Cylinder Check Form".

**Agreement**

I here by authorize \_\_\_\_\_ (Name of nominated attending physician) to provide the airlines with the information, required by those airline's 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 concerned and that the carrier does not assume any special liability exceeding those conditions / tariffs.

I agree to reimburse the carrier upon demand for any special expenditures or costs in connection with my carriage

Date: \_\_\_\_\_

Passengers signature: \_\_\_\_\_  
(or a Representative)