

Information Sheet for Passengers Requiring Special Assistance – Special Assistance Form



PASSENGER INFORMATION

Name, first name _____ Title _____ Age _____ Gender _____
Phone, incl. country/area code _____ E-mail _____

PASSENGER NAME RECORD (PNR)

ROUTING

From _____ To _____ Flightnbr. _____ Class _____ Date _____

NATURE OF DISABILITY AND/OR REQUIRED ASSISTANCE

IS THE PASSENGER ABLE TO SIT IN AN UPRIGHT POSITION ON A REGULAR PASSENGER SEAT? yes no

STRETCHER TRANSPORT REQUIRED yes no

STCR Must travel on a stretcher.
This requires medical assistance, either nurse/paramedic or a physician.

ESCORT FOR THE JOURNEY REQUIRED yes no

Designated escort (Name) _____

Medical qualification physician nurse/paramedic none PNR (if different)

other applicable person (Name) _____

WHEELCHAIR SERVICE OR ASSISTANCE FOR BOARDING/DE-BOARDING REQUIRED? yes no

WCHR Ambulant but impaired in walking: Needs assistance in terminal to/from gate, needs wheelchair or similar when passengers are boarded/d disembarking 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/d disembarking (e.g. on passenger steps). Does not need assistance in the aircraft cabin to/from seat, toilets and with meals.

WCHC Non-ambulant: Needs also assistance in the aircraft to/from seat, toilets and possibly with meals.
Mind: Cabin crew provides assistance in preparation for eating only.

Own wheelchair WCMP – operated with manual power Collapsible Size (W/H/L cm) _____ Weight (kg) _____

Battery powered wheelchair please provide details via <https://www.austrian.com/at/en/contact-form-medical-request>

AMBULANCE TO/FROM AIRPORT REQUIRED yes no

phone/E-mail _____

Organisation (organization and expenses must be absorbed by insurance/passenger)

ASSISTANCE/SUPPORT WHILE IN THE AIRPORT REQUIRED yes no

Please specify: _____

OTHER ASSISTANCE/SUPPORT WHILE IN THE AIRPORT REQUIRED (NOT WHEELCHAIR) yes no

Please specify: _____

SPECIFIC NEEDS/SUPPORT/EQUIPMENT REQUIRED IN-FLIGHT/ON BOARD yes no

Please specify (e.g. special meal, extra seat, type of equipment, etc.)
Any arising expenses on account of passenger

Technical clearance issued by airline yes no

FREMEC (FREQUENT MEDICAL TRAVELLER CARD) yes no

Valid until _____ Issued by _____

I acknowledge, if accepted for carriage, my journey will be subject to the general conditions of carriage/tariffs of Austrian Airlines AG concerned and that Austrian Airlines AG does not assume any special liability exceeding those conditions. I am prepared at my own risk, to bear any consequences which the carriage by air may have for my state of health and I release Austrian Airlines AG, its employees, servants and agents from any liability for such consequences. I agree to reimburse Austrian Airlines AG upon demand for any special expenditures or costs in connection with my carriage.

Information Form for Passengers Requiring Medical Clearance – MEDIF 1



Note for the attending physician: The details requested in here will be treated confidentially; they should enable the Medical Services of the airline(s), as it is their obligation, to judge by their specific air medical knowledge and experience if and under what conditions the patient can be permitted to travel by aircraft as requested. These details will also help the Medical Service in issuing appropriate instructions for the patient's care which duly consider both his/her diagnosis and the special circumstances of the requested air journey. Kindly answer all questions by cross or in block letters, as necessary. Please fill in this form on your PC to enhance readability and clarity. You can easily typewrite into the grey fields. Thank you for your cooperation!

PATIENT

Name, first name _____ Date of Birth _____
Sex _____ Height _____ Weight _____

ATTENDING PHYSICIAN

Name, first name _____ Address _____
E-mail _____ Phone, incl. country/area code _____ Fax _____

DIAGNOSIS (INCLUDING SHORT HISTORY, ONSET OF CURRENT ILLNESS, EPISODE OR ACCIDENT AND TREATMENT, SPECIFY IF CONTAGIOUS)

Nature and date of any recent and/or relevant surgery _____

CURRENT SYMPTOMS AND SEVERITY

Date of onset _____

Will a 25% to 30% reduction in the ambient partial pressure of oxygen (relative hypoxia) affect the passenger's medical condition? (Cabin pressure to be the equivalent of a fast trip to a mountain elevation of 2.400 meters (8.000 feet) above sea level) yes no not sure

ADDITIONAL CLINICAL INFORMATION

a. Anemia	<input type="checkbox"/> yes	<input type="checkbox"/> no	If yes, give recent result in grams of haemoglobin per litre _____
b. Psychiatric conditions	<input type="checkbox"/> yes	<input type="checkbox"/> no	If yes, see Part 2
c. Cardiac disorder	<input type="checkbox"/> yes	<input type="checkbox"/> no	If yes, see Part 2
d. Normal bladder control	<input type="checkbox"/> yes	<input type="checkbox"/> no	If no, give mode of control _____
e. Normal bowel control	<input type="checkbox"/> yes	<input type="checkbox"/> no	
f. Respiratory disorder	<input type="checkbox"/> yes	<input type="checkbox"/> no	If yes, see Part 2
g. Does the patient require oxygen at home?	<input type="checkbox"/> yes	<input type="checkbox"/> no	If yes, specify how much _____
h. Oxygen needed during flight?	<input type="checkbox"/> yes	<input type="checkbox"/> no	If yes, specify <input type="checkbox"/> 2 LPM <input type="checkbox"/> 4 LPM other _____
i. Seizure disorder	<input type="checkbox"/> yes	<input type="checkbox"/> no	If yes, see Part 2

ESCORT

a. Is the patient fit to travel unaccompanied?	<input type="checkbox"/> yes	<input type="checkbox"/> no
b. Is the patient able to sit in a usual aircraft seat?	<input type="checkbox"/> yes	<input type="checkbox"/> no
c. Is the patient able to embark/disembark independently?	<input type="checkbox"/> yes	<input type="checkbox"/> no
d. If yes, who should escort the passenger?	<input type="checkbox"/> yes	<input type="checkbox"/> no
e. If other, is the escort fully capable to attend to all above needs?	<input type="checkbox"/> Doctor	<input type="checkbox"/> Nurse/Paramedic <input type="checkbox"/> Other
f. If other, is the escort fully capable to attend to all above needs?	<input type="checkbox"/> yes	<input type="checkbox"/> no

MOBILITY

a. Able to walk without assistance	<input type="checkbox"/> yes	<input type="checkbox"/> no
b. Wheelchair required for boarding	<input type="checkbox"/> to aircraft	<input type="checkbox"/> to seat

MEDICATION LIST (INCL. DOSES)

OTHER MEDICAL INFORMATION

Information Form for Passengers Requiring Medical Clearance – MEDIF 2



CARDIAC CONDITION

a. Angina yes no When was last episode? _____
Is the condition stable? yes no
Functional class of the patient? No symptoms Angina at rest
 Angina with moderate exertion Angina with minimal exertion
Can the patient walk 100 metres at a normal pace or climb 10-12 stairs without symptoms? yes no

b. Myocardial infarction yes no Date _____
Complications? yes no If yes, give details _____
Stress EKG done? yes no If yes, what was the result? _____ MET or _____ Watt
If angioplasty or coronary bypass, can the patient walk 100 metres at a normal pace or climb 10-12 stairs without symptoms? yes no

c. Cardiac failure yes no When was last episode? _____
Is the patient controlled with medication? yes no
Functional class of the patient? No symptoms Shortness of breath (SOB) with moderate exertion
 SOB with minimal exertion Shortness of breath at rest

d. Syncope yes no When was last episode? _____
Investigations yes no If yes, state results _____

CHRONIC PULMONARY CONDITION

a. Has the patient had recent arterial blood gases? yes no
 yes no

b. Blood gases were taken on room air Oxygen litres per minute (LPM) _____
If yes, what were the results pCO2 [kPa/mmHg] _____ pO2 [kPa/mmHg] _____
% Saturation _____ Date of exam _____

c. Does the patient retain CO2? yes no

d. Has his/her condition deteriorated recently? yes no

e. Can patient walk 100 metres at a normal pace or climb 10-12 stairs without symptoms? yes no

f. Has the patient ever taken a commercial aircraft in his/her current medical status? yes no
If yes, when? _____ Did the patient have any problems? _____

PSYCHIATRIC CONDITIONS

a. Is there a possibility that the patient will become agitated during flight? yes no

b. Has he/she taken a commercial aircraft before? yes no
If yes, date of travel? _____ Did the patient travel alone escorted

SEIZURE

a. What type of seizures? _____

b. Frequency of the seizures _____

c. When was the last seizure? _____

d. Are the seizures controlled by medication? yes no

PROGNOSIS FOR THE TRIP

Good Poor

Physician signature (or facsimile) _____ Date _____

Note: Cabin attendants are not authorized to give special assistance (e.g. lifting, feeding aid) 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 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.