MEDIF

Standard medical information form for air travel

Answer ALL the questions. Write an (x) in the boxes "YES" or "NO."
PRINT or TYPE your answers.

PART 1

To be completed by the passenger

A	Name of passenger					Age
	Travel insurance / Travel insurance no.					
B	Proposed itinerary	From	To	Date	Reservation code	Transfers from one flight to another require MORE time to connect
C	Office or agency				Telephone Number	
D	Does the passenger need a wheelchair? Yes ☐ No ☐		Can the passenger get around themselves for short distances? Yes ☐ No ☐		Passengers traveling with their own battery-operated wheelchair must check the requirements for the transportation of dangerous goods at **www.latam.com**	
E	PROPOSED COMPANION: name, sex, age, profession and job, segments if they aren't the same as the passengers', in the case of an unqualified person, note: TRAVEL COMPANION				In the case of passengers with impaired vision or hearing, indicate if they will travel with an assistance dog.	
	If the person is traveling alone, indicate a contact person, name and telephone number					
F	The passenger responsible for hiring transportation services for boarding and disembarkation, to/from the ambulance to the airplane seat	Ambulance company:				
		Ambulance contact telephone number:				
		Destination address:				

G	Other land preparation needs	Yes ☐ No ☐	If you answered YES, specify below each item (a) Agreement with the Airline or other organization, (b) Who will pay for the expense and (c) telephone number(s) and corresponding addresses or person that provides assistance to the passenger
1	Preparations for delivery at the airport of departure	Yes ☐ No ☐	Please specify _____ _____
2	Preparations for delivery in points of connection	Yes ☐ No ☐	Please specify _____ _____
3	Preparations for assistance at point of arrival	Yes ☐ No ☐	Please specify _____ _____
4	Other preparations or important information	Yes ☐ No ☐	Please specify _____ _____
H	Special in-flight needs such as extra seat (adjacent seat only), special food (only for international flights)	Yes ☐ No ☐	Please specify _____

Passenger declaration
I authorize DR. _____ to provide LATAM airlines group with the information their medical departments need in order to determine if I am apt for air travel and therefore relieve my doctor of his/her ethical obligations with respect to this and I agree to pay for said doctor's respective fees.
I am aware that if transportation is accepted, my trip will be subject to the general transportation conditions and fares of the transporting company and that the transporter will not assume any responsibility that exceeds said conditions and fares.
At my own risk, I take responsibility for any consequence arising from air travel that may affect my health. I relieve the transporter, its employees and its agents from responsibility for such consequences, especially for (but not limited to) expenses arising from pre-existing health conditions. I relieve the transporter of all responsibility with respect to any expenses related with my health if a flight is canceled or delayed due to security reasons or force majeure.
I agree to reimburse the transporter for any special expenses or costs related with my transportation.
I accept that the airline may deny me boarding if my condition does not coincide with the information I have provided or if my boarding puts other passengers' health or flight operations at risk.

IMPORTANT:
When needed, this must be read by the passenger, dated and signed by the passenger or in his/her name

Place	Date	Signature of the passenger	Contact telephone number

MEDIF

Medical information sheet (For official use only)

The objective of this form is to provide the information the airline's medical departments need to evaluate the passenger's conditions for travel. If the passenger is accepted, this information will allow us to provide instructions for the passenger's well-being and comfort. We ask that the treating physician answer all questions, writing an (x) in the box for "yes" or "no" and/or providing concise and precise answers.

We recommend the form be filled out in print

PART 2

To be completed by treating physician

This form must be completed within a maximum of 10 days before flight departure and delivered to the company at least 48 hours before the trip.

MEDA 01 Passenger information	Full name of patient		
	Sex		Age
MEDA 02 Medical information	Name of treating physician		
	Taxpayer identification number/ID/National identity card		Contact Telephone number
	Doctor's specialization		email
MEDA 03 Current diagnosis and patient background	Doctor's report (doctor must attach detailed diagnosis)		
	Current medical/surgical diagnosis (must say if symptoms are resolved/high)		
	Medical history	1. 2. 3. 4. 5.	
	Day/month/year of first symptoms		
	Date of current diagnosis or time with diagnosis		
	Is the passenger fit for air travel? Yes ☐ No ☐		
MEDA 04 (Risk during the trip)	Prognosis for the trip Risk that the trip will be life-threatening: Low or no risk ☐ Average ☐ High ☐ Flying is not recommended ☐		
MEDA 05	Does the patient have an illness that is contagious and/or transmittable while traveling? Yes ☐ No ☐		
	Start date and type of illness		
MEDA 06	Does the patient associated with the previous diagnosis present an alteration with respect to: Bowel control Yes ☐ No ☐ Behavior Other:		
MEDA 07	Can the patient sit up vertically during the flight? Yes ☐ No ☐ Does the patient need a stretcher? Yes ☐ No ☐		
MEDA 08 (Patient independence)	If the patient is independent during the flight to: Eat Yes ☐ No ☐ Go to the bathroom Yes ☐ No ☐ Understand safety instructions Yes ☐ No ☐ Others_____		
MEDA 09 Companion	If traveling with a companion, specify the type of companion(*): Relative ☐ Doctor ☐ Nurse ☐ Paramedic ☐ Other:		
	(*)The adult companion must be physically and mentally apt to perform in the cabin of an airplane and to care for the passenger in the event of an emergency or service conditions (physiological and feeding)		
MEDA 10 (Oxygen)	Does the patient need oxygen when in flight? Yes ☐ No ☐ Oxygen saturation percentage ☐		
	Will the patient travel with his/her own portable oxygen concentrator-POC? Yes ☐ No ☐ Model: Brand:	Duration of flow LT/min ☐	Duration of battery: ☐ (IT MUST LAST 150% OF THE FLIGHT HOURS including stopovers and waiting times).....Hrs.
	Can it be disconnected for short periods of time if needed? Yes ☐ No ☐		
	Does the patient travel with other respiratory assistance medical devices? CPAP/ BiPAP / VPAP / APAP / EPAP / Humidifier/ Nebulizer? Type of device (Ex. APAP): Model: Brand:		
MEDA 11 MEDA 12	Deliver the list of patient medication and method of administration (all are the exclusive responsibility of the patient) 1. 2. 3. 4. 5. 6.		
	Does the patient need medication before the flight? Yes ☐ No ☐		
	Does the patient need medication during the flight? Yes ☐ No ☐		

MEDA 13 **MEDA 14**	Does the patient require hospitalization? (If the answer is yes, indicate the arrangements made, if they have not been made, indicate the "action not taken." The certificate of the center where the patient will be hospitalized must be attached.)	Yes ☐ No ☐	Does the patient require hospitalization during stopovers?	Yes ☐ No ☐	Does the patient require hospitalization and/or an ambulance upon arrival to the destination?	Yes ☐ No ☐
MEDA 15	If the patient has a coagulation disorder and/or a history of thrombosis, cardiac arrhythmia or fracture in lower extremity in trips longer than 3 hrs, etc., will he/she be receiving treatment with an anticoagulant to be taken orally or by injection when traveling? Yes ☐ No ☐ Specify which _____					
MEDA 16	According to the patient's current/main disease, is he/she stable to tolerate total flight hours, including stopovers, without complications? Yes ☐ No ☐					
MEDA 17 (Surgeries)	Type of surgery Open ☐ Laparoscopy ☐ Other ☐					
	Complications during surgery Yes ☐ No ☐					
MEDA 18	Does the patient need a wheelchair? Yes ☐ No ☐ Can the patient bend his/her knees during the trip? Yes ☐ No ☐ Can the patient bend his/her hips during the trip? Yes ☐ No ☐					
MEDA 19 (Psychiatry)	Does the patient suffer from a psychiatric illness? Yes ☐ No ☐ Which one? Schizophrenia ☐ Bipolarity ☐ Other _____ Is the patient stable/under control? Yes ☐ No ☐					

Important:
1. Passengers in a stretcher always need an ambulance. This must be requested and paid by the passenger.
2. Oxygen cylinders will be provided by the airline (dry oxygen only) and the service will only be provided on board. The passenger is responsible for informing the crew when the cylinder needs to be changed. In addition, the passenger must supply his/her own oxygen at the destination.
3. Oxygen concentrators must be approved by the aeronautical authority and must be provided by the passenger.
4. LATAM does not provided physiological items.
5. The airline may condition acceptance of transportation and/or deny boarding if, according to the medical history included in this form, there are risks for the passenger's or others' health and also if the passenger's health condition does not coincide with the form at the time of boarding.
Read the terms and conditions at **www.latam.com** section: Information for your trip

The undersigned, DR: _____ declares that the patient is in condition to fly with the precautions described above, without risk of worsening his/her condition due directly to the flight.

Date	Place	Attending physician's signature