This form is interactive. You can type your information into the form and then print before you sign. If you fill in by hand, please be sure to print legibly; this will help avoid processing delays.

Fees for completion of form are the responsibility of the traveller/patient.

Incomplete forms will not be reviewed or processed. Please be sure to fill it out completely and date where requested.

Traveller information section - to be completed by traveller/patient

Enter name exactly as shown on travel identification (generally a passport).

Important notes:

- If the Traveller chooses to purchase additional or special seating and is not subsequently approved before travel, Swoop will not give a refund, credit or other compensation. If the Traveller is not approved before the flight, the change or cancellation fees and guidelines for the flight segments reserved will apply.
- **The final determination of a traveller's fitness to fly will be made by the Swoop medical team** after reviewing all medical information provided by the traveller and physician.
- This form's sole use is to determine accommodation(s) provided by Swoop for Swoop marketed and operated flights. This will not provide accommodations for services offered by third party vendors, suppliers or tour operators.

Swoop medical information form - Confidential fax: 1-844-212-5513 or email: medical@flyswoop.com

***Traveller first name:**

***Traveller last name:**

Title

***Birthdate:** (MM/DD/YYYY)

***Gender:**

***Preferred contact number:**

Alternate contact number:

***Preferred email:**

Alternate email:

***Traveller address:**

***City:**

***Province/State:**

***Postal code/Zip:**

***Country:**

***Have you previously been approved for an AP number?**

◯ No ◯ Yes

If yes, what is your AP number:

Intended date of travel: **From:** **To:**

(MM/DD/YYYY)

Guardian or decision maker

If it is not suitable to contact the traveller directly, who is the guardian or decision maker?
Please provide documentation to indicate legal guardianship and/or power of attorney.

Guardian name: **Relationship to traveller:**

Contact number:(If different than travellers's contact number) **Email:** **(If different than traveller's email)**

Consent and agreement

I _____ consent and authorize my treating medical physician (MD) _____ to provide and discuss the information on this form or other medical information with Swoop as required to facilitate my safe air travel. This consent and authorization extends to any medical professional with whom my physician has identified as holding information relevant to my assessment by Swoop, or any support organization arranging travel on my behalf. I consent to the collection and retention of the medical information on this form for the purposes of facilitating travel, with the understanding that this medical information will be kept confidential in accordance with Swoop's Privacy Policy.

I understand that if approved, Swoop will provide appropriate accommodations to me. I agree to provide updated medical information for any significant change(s) to my health, and to abide by the terms of any medical accommodation including personal attendant requirements and restrictions applicable to travel companions.

***Signature (traveller/guardian/or decision maker):** ***Date:** (MM/DD/YYYY)

Interpreter

Understanding and consent from a non-English speaking traveller
I acknowledge that I have interpreted the information on this form to the person giving consent and I believe that the person understands the information provided and consents to the disclosure of this information by their treating medical physician to Swoop.

Name: **Signature:** **Date:** (MM/DD/YYYY)

Medical physician (MD) details

All remaining pages must be completed by a medical physician.

*Required fields

*Medical physician (MD) name:

*License number:

*Country or province of registration:

*Physician's location (town or city):

Email address:

*Phone number:

*Fax:

Date of first visit: (MM/DD/YYYY)

Is this patient regularly in your care:

○ No ○ Yes

Physician's certification:

By signing this form, I understand that I am providing information which Swoop will use to determine my patient's ability and/or accommodations needed to travel safely. I accordingly certify that all of the information I have provided is complete, true and accurate to the best of my knowledge.

If there is another medical professional or support organization with whom Swoop may need to discuss information relevant to your patient's fitness to fly please provide their information below:

Please include all occupation(s) and contact information (email/phone numbers):

*Physician's signature:

*Date: (MM/DD/YYYY)

Application must be dated within one year of travel date.

*As a physician, please initial to indicate your awareness that:

☐ *A commercial aircraft cabin is not appropriate for patients that need access to advanced medical care, have a serious illness or those who are at risk for complications onboard as long flights over water may have limited or no option for landing to obtain ground medical services. Patients with these considerations must postpone travel or travel by air ambulance.

☐ *Reduced atmospheric pressure: cabin air pressure changes greatly after take-off and landing. Gas expansion and contraction can cause pressure effects.

☐ *Cabin pressure is the equivalent of a fast trip to a mountain elevation of 2400 meters (8000 feet) above sea level.

***Will a 25% to 30% reduction in the ambient partial pressure of oxygen (relative hypoxia) affect your patient's medical condition?**

◯ No ◯ Yes

***Initial to indicate your prognosis for a safe flight:**

Good _____ Fair _____ Poor_____

Please elaborate:

Please select the applicable statement for your patient, and complete the section(s) as directed.

My patient:

☐ has a medical condition(s) that air travel may affect, or require an onboard accommodation. Complete Section 1.

☐ requires a personal attendant inflight. Complete Sections 1 and 2 (restrictions apply).

☐ requires an extra seat for obesity. Complete Section 1 and 3 (restrictions apply).

☐ is travelling to or from the United States. Complete Section 4.

Section 1: Fit to fly information

Section 1 is required for all patients, except those travelling to/from the U.S. Although Section 1 is not required for travel to/from the U.S., we recommend that it is completed so that we can ensure safety for travel and assess if on board accommodations are required.

***Primary diagnosis:**

***Date of onset:** (MM/DD/YYYY)

Secondary diagnosis:

***Current symptoms and severity:**

***Treatment and prescribed medication:**

***Recent, relevant or planned surgery/sedation:**

◯ No ◯ Yes

Nature:

***Date:** (MM/DD/YYYY)

***Compliant with treatment?**

◯ No ◯ Yes

Currently hospitalized?

◯ No ◯ Yes

Date of discharge? (MM/DD/YYYY)

Discharge to:

◯ Home ◯ Facility

*Disabling allergies to cats?

◯ No ◯ Yes

If yes, please specify symptoms, treatment and stability for travel:

Wheelchairs, transfers and medical equipment

*Is a wheelchair required by your patient?

◯ No
◯ Yes, at all times and requires transfer to/from seat
◯ Yes, for distance only; can climb steps (>50 metres)
◯ Yes, for distance; can't climb steps

Can your patient self-transfer to/from a wheelchair to the seat of the aircraft?

◯ No ◯ Yes

If transfer assistance is required, can your patient be transferred by a Swoop Customer Service Agent?

◯ No ◯ Yes If no, why?

Please list any medical equipment your patient will require during the flight:

Oxygen needs

◯ Not applicable (skip) ◯ Yes - Please complete the following Type:

Swoop does not accept personal oxygen cylinders. Swoop will accept portable oxygen concentrators (POC).

Oxygen saturation:

% ◯ Room air ◯ Oxygen

L/min continuous oxygen

Measured via:

◯ Nasal prongs ◯ Mask

Max L/min required during flight:

Does the patient use continuous oxygen at home?

◯ No ◯ Yes

Will your patient require continuous oxygen inflight?

◯ No ◯ Yes

Is your patient using a personal oxygen concentrator (POC)?

◯ No ◯ Yes

Cardiac condition

◯ Not applicable (skip) ◯ Yes - Please complete the following Type:

a) Angina **Date:** (MM/DD/YYYY) **The patient's condition is:**

◯ No ◯ Yes ◯ Stable ◯ Unstable

If unstable, please select one:

◯ No symptoms ◯ Angina at rest ◯ Angina w/ major effort ◯ Angina w/ minor effort

b) Myocardial infarction **Date of event:** (MM/DD/YYYY) **Complications:**

◯ No ◯ Yes ◯ No ◯ Yes

Angiogram/angioplasty: **Procedure date:** (MM/DD/YYYY)

☐ Angiogram ☐ Angioplasty

c) Cardiac failure **Class 1-4:** **Other details:**

◯ No ◯ Yes

d) Syncope **Last episode:** (MM/DD/YYYY) **Investigations:**

◯ No ◯ Yes ◯ No ◯ Undiagnosed ◯ Yes

If investigated, result/cause:

Chronic pulmonary condition

◯ Not applicable (skip) ◯ Yes - Please complete the following Type:

a) Does patient have shortness of breath?

◯ No ◯ Yes, with major efforts ◯ Yes, with light efforts ◯ Yes, at rest

b) Does the patient retain CO2?

◯ No ◯ Yes

c) Has the patient deteriorated recently? **Details:**

◯ No ◯ Yes

Cognitive/behavioral or psychiatric conditions

◯ Not applicable (skip) ◯ Yes - Please complete the following

Diagonosis/explain: (250 character limit)

Is there a possibility that the patient will become agitated during flight?

◯ No ◯ Yes

If yes, please explain:

If yes, and an attendant would mitigate their condition, please complete Section 2. Additional comments:

Communicable disease

***Does the patient have an active communicable infection/disease that can be transmitted or pose a direct threat to the health and safety of other individuals during the normal course of their travel?**

◯ Not applicable (skip) ◯ Yes - Please complete the following

Diagonosis/explain: (250 character limit)

Are any precautions needed to prevent the spread of infection or disease during the course of their travel?

◯ No ◯ Yes **Specify:**

Seizures

◯ Not applicable ◯ Yes

Type:

Frequency:

Date of last seizure: (MM/DD/YYYY)

Are the seizures stable and controlled by medication?

◯ No ◯ Yes

Is oxygen or suction required to treat the seizure?

◯ No ◯ Yes

*Has the patient ever flown on a commercial aircraft with the medical condition/injury indicated on this form?

◯ No ◯ Yes

When: (MM/DD/YYYY)

*How did they travel?

◯ Alone ◯ With attendant

Has your patient ever suffered from any problems/medical complications during a commercial flight? If yes, please explain:

(Provide date and details)

Section 2: Applicable to in-cabin assistance on domestic flights (Canada only)

◯ Not applicable (skip) ◯ Yes - Please complete the following

Once onboard the aircraft, is your patient capable of:

Travelling unaccompanied in their current medical condition? ◯ No ◯ Yes

Using the toilet unaided (once inside the lavatory)? ◯ No ◯ Yes

Taking prescription medication unaided? ◯ No ◯ Yes

Managing their meals unaided? ◯ No ◯ Yes

If no, what assistance is required? Check all that apply.

☐ Feeding ☐ Opening containers ☐ Set-up/orientation

Independently evacuating the aircraft in the event of an emergency? ◯ No ◯ Yes

Donning the emergency oxygen mask independently? ◯ No ◯ Yes

Does your patient require a medically qualified attendant in order to travel? ◯ No ◯ Yes

If yes, what specific type of assistance is required?

Section 3: Seating accommodations for obesity (Domestic flights Canada only)

◯ Not applicable (skip) ◯ Yes - Please complete the following

We require five days to adjudicate.

☐ **Extra seats(s) for obesity** (must also complete Section 1: Fit to fly information)

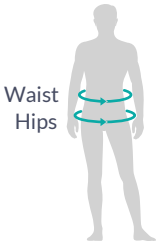
Provide the patient's circumference (taken while standing)**:**

Height: _____ cm

Weight: _____ kg

Waist at umbilicus: _____ cm

Maximum girth of hips above gluteal fold: _____ cm



Additional information

Please add any additional relevant information.

Section 4: Travel only between Canada and the USA

◯ Not applicable (skip) ◯ Yes - Please complete the following

If your patient consents to providing Swoop with additional medical information, we strongly recommend that you complete Section 1 as this will help us ensure your patient's safety in the aircraft's relative hypoxic environment, and will improve our ability to identify any onboard accommodation that may be required/available.

1. Prognosis for a safe flight with no extraordinary medical attention:

◯ Good ◯ Poor - if the patient has any of the following:

a) Has an unstable medical condition;
b) Has a medical condition that may worsen at altitude in a hypoxic environment
c) May require medical assistance or emergency medical equipment during flight

2. Communicable diseases

Does the patient have a communicable infection or disease that would under their current status, be transmitted or pose a direct threat to the health and safety of other individuals during the normal course of their travel?

◯ No ◯ Yes

Are there any precautions needed to prevent the spread of infection or disease during the course of their travel?

◯ No ◯ Yes Specify:

3. Does the patient have a fused knee or immobilized lower limb?

◯ No ◯ Yes

If yes, we may request further medical information to provide this accommodation. You may opt to complete Section 1 - Fitness to travel.

◯ No ◯ Yes

Physician's consent:

By signing this form, I understand that I am providing information which Swoop will use to determine my patient's ability and/or accommodations needed to travel safely. I accordingly certify that all of the information I have provided is complete, true and accurate to the best of my knowledge.

Signature:

Date: (MM/DD/YYYY)

*If only Section 4 is completed, this must be dated within 15 days of travel and travel must be completed within 15 days of approval.