WestJet Medical Information Form

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

Fees for completion of this form are the responsibility of the patient.
Please fill in completely and date where requested; accommodation decisions will not be made with incomplete forms. Submit completed forms to Swoop by e-mail to medical@flyswoop.com or by fax to 1-844-212-5513

PATIENT INFORMATION

Last name **(Provide name exactly as shown on travel identification)** | First name | Middle name

Birthdate MM/DD/YYYY / /

Gender
Female Male

E-mail

Contact number XXX-XXX-XXXX

Address

Town/City

Province/State | Postal code/ZIP | Country

Swoop AP Number *(only if you have had a previous accommodation approval)*

Intended date of travel MM/DD/YYYY / /

Flight origin | Flight destination

ALTERNATE CONTACT

Please provide an alternate contact (can be parent, guardian or decision maker) if patient is a child or cannot advocate for themselves. The alternate contact will have access to this medical information, may speak on patient's behalf for follow up questions and may be provided details regarding patient's on board accommodation.

Name

Relationship

E-mail *(if different than patient's)*

Contact number *(if different than patient's)* XXX-XXX-XXXX

Patient name

PREVIOUS TRAVEL HISTORY

Have you ever flown on a commercial aircraft in the medical condition indicated on this form?	No	Yes
How did you travel?	Alone	Accompanied
When?		
Have you suffered from any medical complications that required medical intervention during a commercial flight?	No	Yes

If yes, please provide date and details.

PATIENT CONSENT AND AGREEMENT

I ___________________________ consent and authorize my treating medical professionals to provide and discuss the information on this form, other medical information or my previous travel history with Swoop as required to facilitate my safe air travel. This consent and authorization extends to any medical professional 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 *(patient/guardian/or decision maker)*	**Date** MM/DD/YYYY
	/ /

Patient name

PHYSICIAN DETAILS

All remaining must be completed by a **medical physician**.

Physician name

License number

Province/Country of registration

Town/City

E-mail *(optional)*

Contact number XXX-XXX-XXXX

Fax XXX-XXX-XXXX

Date of first visit MM/DD/YYYY

/ /

Is the patient regularly in your care? No Yes

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. Include all occupation(s) and contact information (e-mail/phone numbers)

Physicians are required to complete mandatory Section 4, initial and date all pages where indicated.
Please select the applicable statement for your patient and complete as directed.

My patient is requesting:

Request	Action
Confirmation they are medically fit to fly and/or a seating accommodation	*Complete section 1*
An extra seat for obesity	*Complete sections 1 and 2*
A personal attendant	*Complete sections 1 and 3*
An accommodation inflight to or from the United States	*Complete section 4*

Section 4 is mandatory.

Physician initials

Date

/ /

Patient name

SECTION 1: FIT TO FLY INFORMATION

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

Diagnosis

Date of onset MM/DD/YYYY
/ /

Current symptoms and severity

Treatment/prescribed medication(s)

Recent, relevant or planned surgery/sedation No Yes

Nature

Date MM/DD/YYYY
/ /

Currently hospitalized? No Yes

If yes, will be discharged to Home Facility

Date of discharge MM/DD/YYYY
/ /

Physician initials

Date
/ /

Patient name

Pulmonary

Not applicable (skip)

Yes - Please complete the following

Condition Type

Does the patient have shortness of breath?

No

Yes, with light efforts

Yes, with major efforts

Yes, at rest

Has the patient deteriorated recently? No Yes

Details

Oxygen saturation

% L/min Continuous oxygen Pulse setting Room air

Will your patient require oxygen inflight? No Yes

Max pulse setting

Does the patient use oxygen at home? No Yes

For personal oxygen concentrator use, please see accessible services. Patient supplied gaseous oxygen cylinders are prohibited on board all Swoop operated flights.Swoop does not provide medical oxygen for purchase on board.

Physician initials

Date / /

Patient name

Cardiac

Not applicable (skip)

Yes - Please complete the following

Condition Type

A. Angina

No

Yes

Date MM/DD/YYYY

/ /

The patient's condition is

Stable

Unstable

If unstable, please select one

No symptoms

Angina at rest

Angina w/major effort

Angina w/ minor effort

B. Myocardial infarction

No

Yes

Date MM/DD/YYYY

/ /

Complications

Stable

Unstable

Angiogram/Angioplasty

Angiogram

Angioplasty

Procedure date MM/DD/YYYY

/ /

C. Cardiac failure

No

Yes

Class 1-4

Details

D. Syncope

No

Yes

Last episode MM/DD/YYYY

/ /

Investigations

No

Yes

Undiagnosed

If investigated, result/cause

Physician initials

Date

/ /

Patient name

Seizures

Not applicable (skip) Yes - Please complete the following

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 manage the seizure?	No	Yes

Cognitive/behavioral or psychiatric

Not applicable (skip) Yes - Please complete the following

Condition type/explain

Is there a possibility the patient's condition will deteriorate during flight?	No	Yes

If yes, please explain

Please complete Section 3 if an attendant would mitigate patient's condition during flight.

Seating accommodations

Not applicable (skip) Yes - Please complete the following

Please indicate the seating accommodation and provide medical rational to support.

Physician initials

Date

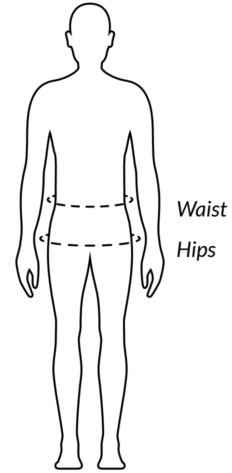
/ /

Patient name

SECTION 2: SEATING ACCOMMODATIONS FOR OBESITY

Not applicable (skip)   Yes - Please complete the following

Height	Weight
cm	kg
Waist around umbilicus	Maximum girth around hips above gluteal fold
cm	cm



SECTION 3: ASSISTANCE REQUIREMENTS

Not applicable (skip)   Yes - Please complete the following

Once **on board** the aircraft, is your patient capable of:

Taking medication unaided?		No	Yes
Using the toilet unaided (once inside the lavatory)?		No	Yes
Managing their meals unaided?		No	Yes
If no, what assistance is required?	Feeding	Opening containers	Set-up/orientation
Does your patient require a medically qualified attendant in order to travel?		No	Yes

Indicate additional or specific assistance needs your patient requires on board the aircraft

Physician initials

Date
/ /

Patient name

Wheelchairs, transfers and medical equipment

Do not use this form to request the use of a wheelchair. See https://www.flyswoop.com/accessible-services for advance notice requirements and more information.

Not applicable (skip) Yes - Please complete the following

Will your patient require a wheelchair for

Distance Transfer from door aircraft to their seat At all times

Can your patient ascend/descend steps?	No	Yes
Can your patient self-transfer to/from a wheelchair to the seat of the aircraft?	No	Yes
Can your patient stand, pivot and weight bear?	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

Additional Medical Information

Not applicable (skip) Yes - Please complete the following

Please provide additional medical information you feel is relevant to your patient's situation or accommodation request.

Physician initials

Date / /

Patient name

SECTION 4: MANDATORY FOR ALL PATIENTS

If your patient consents to providing Swoop with additional medical information, we strongly recommend you complete Section 1. This information may help identify further onboard accommodations that may be required to ensure a safe flight.

Prognosis for a safe flight with no extraordinary medical attention

Good

Poor if the patient has any of the following:
a) An unstable medical condition
b) A medical condition that may worsen at altitude in a hypoxic environment
c) May require medical assistance or emergency medical equipment during flight

Is your patient fit to fly? No Yes

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

No Yes

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

Condition type/explain

Are there any precautions needed to prevent the spread of infection or disease during the course of their travel? No Yes

Explain

Physician initials **Date**

Patient name

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. If only section 4 is completed, this must be dated within 10 days of travel and travel must be completed within 10 days of approval.

Signature	Date MM/DD/YYYY
	/ /

Physician office stamp required