SPRING JAPAN 春秋航空日本

MEDICAL INFORMATION FORM (MEDIF) **【to be completed by a DOCTOR】**

Pl ease fill in all the following check boxes ☑. Also, please inform us of necessary symptoms for air travel by FAX in details. (Please contact us within the call center business hours.) If necessary, we may contact with the medical organization for clarification of the information. FAX/0476-27-5606 Opening Hour/09:00~17:30

CUSTOMERS (PATIENTS) INFORMATION			
NAME, INITIAL(S)		AGE	GENDER ☐MALE ☐FEMALE
MEDICAL DATA (Name of Disease)			
DIAGNOSIS in details	*Please write in detail so that non medical personnel are able to understad		
Date of first symptoms (Date of Operation)	DATE:	For expecting mother (estimated delivery date)	DATE:

DIAGNOSTIC CONTENTS			
1	Prognosis for the flight(s) *Please consider the itinerary and it's potential effect on the state of health	☐ Fit to Travel ☐ Not Fit to Travel	Prognosis for the Return Flight ☐ Fit to Travel ☐NOT Fit to Travel Date of Return Flight _____
2	Contagious and communicable Disease ?	☐ Yes → may the disease be infectious to others ? ☐Yes ☐ No ☐No	
3	Can sit upright with seat belt fastened? (during take-off and landing)	☐ Yes ☐ No → **if not, can not travel by the flight**	
4	Is the patient fit to travel unaccompanied ?	☐ Yes → must be aware of equipment and able to operate. ☐ No, must be accompanied by a Doctor or nurse ☐ No, must be accompanied a person who is approved by the Doctor → Name: _____	
5	Oxygen needed in flight ?	☐ Yes → Continuous ? ☐Yes ☐No Liters per minute [ ]ℓ/minute ☐ No	
6	Does patient need any medical equipment in flight ? *If you bring oversized medical equipment that cannot be stored under the seat in front, you may need to purchase another seat.	☐ Yes → if yes, specify, ■The name of Medical Equipment _____ ■Manufacture or Distributor/Product Name _____ ■Type or model number _____ ■Size/Type of Battery _____	

7	Does patient need any MEDICATION in flight?	☐ Yes → if yes, please specify ☐ No
8	Specify more details, if necessary	

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

DOCTOR (PHYSICIAN)			
Print Name	First Name	Last Name	
Signature		Date	
Name of Hospital Medical Organization		Specialized Medical Field	
Phone No.(ext.)		Emergency Contact No.	