# MEDICAL INFORMATION FORM ＜To be completed by ATTENDING PHYSICIAN＞

The attending physician is requested to answer all questions. Enter a check mark(✔) in the appropriate"Yes" or "No" boxes, and/or give precise and concise answers. Please send the Medical Oxygen Cylinders Check Form by fax to 0570-020-179 or by Contact Form on our website at least 5 working days prior to your departure.
If you have any question, please contact to Reservation Center 0570-6666-03. Open Every day 9:00-18:00

## PATIENTS INFORMATION

| | | | | |
|---|---|---|---|---|
| Name | | PNR (Booking Number) | Age | |
| | | | Gender | ☐ Male ☐ Female |
| Diagnosis in details | *Please write so that non medical personnel can understand. | | | |
| When did the first symptoms appear<br>(Date of Operations, if any) | Date: | for expecting mother<br>(Estimated delivery date) | Date: | |

## DIAGNOSIS CONTENT

| | | | | |
|---|---|---|---|---|
| 1 | Prognosis for the flight(s) | ☐ Fit<br>☐ Not Fit | Prognosis for the Return Flight (if any)<br>Date of return flight | ☐ Fit<br>☐ Not Fit |
| 2 | Can the patient use normal aircraft seat with the seatback placed in the Upright Position when so required? (during take-off and landing) | ☐ Yes<br>☐ No | | |
| 3 | Can the patient is fully capable/able to use lavatory, provide self-care(eat, drink…etc.) unattended without assistant from flight crew? | ☐ Yes → ※The patient must be fully knowledgeable in its use.<br>☐ No, Must be accompained by Physician or Nurse<br>☐ No, Must be accompanied by a person who is approved by Physician | | |
| 4 | Dose passenger need Oxygen equipment in flight? | ☐ Yes → ※If "Yes", Liters per minute: ＿＿＿＿ (ℓ/min)<br>☐ No | | |
| | Continous use? | ☐ Yes<br>☐ No | | |
| 5 | Does the patient need medical equipment in flight? | ☐ Yes → ＜The Name of Medical Equipment＞ ＿＿＿＿<br>☐ No ＜Manufacturer of Distributor＞ ＿＿＿＿<br>＜Product name / type or model number＞ ＿＿＿＿<br>＜Size / Type of battery＞ | | |
| 6 | Does patient need any medication in flight? | ☐ Yes → Specify:<br>☐ No | | |
| 7 | Does patient have own mobility assistant device, wheelchair as check-in baggage? | ☐ Yes → Specify: ☐ Foldable (Manual) ☐ Non-foldable (Manual) ☐ Battery-powered (Electric)<br>※If patient has own mobility assistant device, wheelchair, please download and fill in the " Wheelchair Check Form".<br>☐ No | | |
| 8 | Specify more details, if necessary | | | |

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

| PHYSICIAN | | | Date of Submission: |
|---|---|---|---|
| Name(Signature) | | | |
| Hospital Name | | | |
| Telephone Number | | Emergency Telephone Number | |

# Wheelchair Check Form

The attending physician is requested to answer all questions. Enter a check mark(✔) in the appropriate"Yes" or "No" boxes, and/or give precise and concise answers. Please send the Medical Oxygen Cylinders Check Form by fax to 0570-020-179 or by Contact Form on our website at least 5 working days prior to your departure.
If you have any question, please contact to Reservation Center 0570-6666-03. Open Every day 9:00-18:00

| Date of Submission: | | |
|---|---|---|
| Name: | | PNR(Booking Number): |
| E-mail Address: | Age: | Gender: ☐ Male ☐ Female |

Itinerary:

Date: Flight No.: Travel segment(Departure-Arrival): ( - )

Date: Flight No.: Travel segment(Departure-Arrival): ( - )

1. Please let us know your mobility condition in order for us to accommodate your needs.

☐ Unable to walk, require wheelchair at all time ☐ Able to walk but require assistant ascend or descend steps

☐ Able ascend or descend steps by own accord but unable walk long distance

2. Please tell us about your personal mobility assistant device, wheelchair.

☐ No wheelchair

☐ Personal wheelchair → ☐ Manual → ☐ Foldable
☐ Non-foldable

☐ Electric/Battery-powered → ☐ Li-ion Battery
☐ Dry Battery (NiCad, Ni-MH)
☐ Non-Spillable Battery (Wet-cell "sealed")
☐ Spillable Battery (Wet-cell "non-sealed")

3. Please tell us about the design and function of the battery. (Only for battery-powered)

☐ Battery can only be removed by using tool or asking the manufacturer to do
→ ☐ Function to prevent unintentional operation → ☐ YES
☐ NO
→ ☐ Battery terminal can be isolated

☐ Battery can be removed easily by the user
→ ☐ If it is a Li-ion battery, 1 battery is not exceeding 300Wh or 2 batteries are not exceeding 160Wh each.
→ ☐ If it is a Li-ion battery, 1 spare battery is not exceeding 300Wh or 2 spare batteries are not exceeding 160Wh each.

＊Vanilla Air do not accept;

①Li-ion battery which exceeds 1 battery of 300Wh or 2 batteries of 160Wh each can't be accepted if the batteries can be removed easily or the batteries are spare.

②Battery which has no function to prevent unintentional operation and the battery terminal cannot be isolated on condition that the battery can only be removed by using tool or asking the manufacturer to do

＊Please check your wheelchair at the check-in counter, we will assist you to the aircraft with company wheelchair.

＊When checking your electric/battery-powered wheelchair, please inform airport ground staff wheelchair's battery types and battery disconnection and/or insulation instruction if required.

＊Some Over-Sized wheelchairs may not be accepted due to aircraft limitation (cargo door or compartment)

Please tell us the size and weight of your wheelchair.

Length:_____cm Width:_____cm Height:_____cm Weight:_____kg

【If other than traveler, please provide following information】

Name of person prepare the document：_____

Company Name：_____ Position：_____