Request for Air Travel

Please complete all of the questions below as it relates to the client=s request to travel by flight. If you have any questions please contact Howard Thistle at 1 709 679 5743

Section 1 - Client Information and Consent

Clients Full Name:____

Date of Birth:______/______/______ Client ID #:____________________________
dd / mm/ yyyy

CLIENT CONSENT FOR RELEASE OF INFORMATION

I consent to the disclosure of any personal medical information to ** to support my request for coverage of a non-medical escort.

Signature: ____________________________ **Date:**____________________________

Section 2 - Medical Information

This section must be completed and signed by a Physician/Community Health Professional *

**Community Health Professional is a health professional who is a member in good standing of a professional association*

As the **treating** Physician/Community Health Professional I have assessed this client and verify the following: **Please complete all of the following questions.**

Y ~ **N ~** **COGNITION**: Does the client have any limitations with memory, concentration, problem-solving, or safety awareness?

Y ~ **N ~** **SENSES:** Does the client have any significant limitations with sight, hearing or speech?

Y ~ **N ~** **SOCIAL FUNCTIONING:** Does the client have limitations dealing with other people (mental health issues?)

Y ~ **N ~** **PERSONAL NEEDS:** Does the client have limitations in washing/dressing/eating independently?

Y ~ **N ~** **RESPIRATORY FUNCTION:** Does the client have any breathing limitations?

Y ~ **N ~** **BOWEL & BLADDER FUNCTION:** Does the client need help with toileting?

If YES to any of the above, please describe how this affects their ability to travel by ground transportation (car, bus):

Y ~ **N ~** Does the client require a mobility aid for walking?

Y ~ **N ~** Are there any significant limitations to the client lifting/reaching as per normal daily activities?

Y ~ **N ~** Are there any medical limitations to sitting or standing?

How long (in time **OR** distance) can this individual walk?

How does the client normally travel to your office?

If YES to any of the above, please describe:

What is the **main reason for you to recommend** a flight for this client?

What is the key risk if the client does not travel by flight?

Physician/Community Health Professional Signature____

Physician/Community Health Professional Name (please print):________________________________

Role in Client=s medical care: ____

Physician/Community Health Professional Address:_____________________________________

Telephone Number :(________)______________________ Date:______/______/______
dd/mm/yyyy

Fax this completed form to:
Glenwood Mi'kmaq First Nation Band
1 709 679 2344