Medical Section

Hours of Operation
MON-FRI 06:00-20:00 EST
SAT-SUN 06:00-18:00 EST

Email: acmedical@aircanada.ca

Fax: 1 888 334-7717 (toll-free) or 514 205-7567

Telephone: 1 800 667-4732 (toll-free) or (514) 369-7039

To:

Telephone:

Fax:

INSTRUCTIONS FOR THE ATTENDING PHYSICIAN

(This information is for use by the Air Canada physician, who is a specialist in Aviation Medicine.)

If your patient requires supplemental oxygen, with no other co-morbidities, please fill Section 1.

If your patient has a medical condition which may be affected by air travel, please fill Section 2.

If your patient requires an extra seat for reasons of obesity, please fill Sections 2 and 3 (itineraries within Canada only).

If your patient is traveling to or from the United States, only Section 4 is required (and Section 1 if oxygen is required). However, if your patient consents, we strongly encourage you to also fill out Section 2 to help us ensure safety in a hypoxic environment.

Please answer (in block letters) all the questions in order to have your patient travel on Air Canada and return to the above facsimile number as soon as possible. All relevant sections must be signed and dated.

Costs for completing this form are the patient’s responsibility.
Passenger’s Name: [Field] 
Booking Ref.: [Field] 

**PASSenger Information**

For Air Canada use only
Priority: URGENT
Type: Normal

Passenger Name: [Field]
Booking Reference: [Field]
Date of Birth: [Field]
Flight Number: [Field] Date: [Field] From/to: [Field]
Flight Number: [Field] Date: [Field] From/to: [Field]

**Physician Information**

Attending Physician: [Field] Tel.: [Field]
Country or Province of Registration: [Field] Fax: [Field]
Physician License Number: [Field]

**Section 1 – Travelling with Oxygen**

1) **Oxygen**

a) Does the patient already use oxygen on the ground? □ No □ Yes: please provide the following information:
   □ O₂ tank by Nasal Prongs / Mask Flow Rate: _______ Lpm Hours per day: _______
   □ Personal oxygen concentrator (POC) ► Type: __________________________ Setting: □ Pulse □ Continuous
   ► if □ Pulse, settings: 1 2 3 4 5 6 ► if □ Continuous _______ Lpm Hours per day: _______

b) Oxygen saturation: _______% □ Room air □ O₂ _______ Lpm continuous
   □ O₂ POC pulse settings: 1 2 3 4 5 6

c) Choose one of the following options for flight:
   □ Option 1 - Oxygen Request *(provided by Air Canada – nasal prongs only, no mask):
     Oxygen cylinder – required flow: 2 LPM 3 LPM 4 LPM 5 LPM 6 LPM 7 LPM 8 LPM
     Is humidified gaseous oxygen a medical necessity: □ Yes □ No
     Is a pediatric mask required? □ Yes □ No
   □ Option 2 - Personal oxygen concentrator**(passenger provided) – Type: __________________________
     ► if □ Pulse, settings: 1 2 3 4 5 6 ► if □ Continuous _______ Lpm

Prognosis for a safe trip: □ Good □ Guarded □ Poor

If your patient has a medical condition other than his/her need to use oxygen that may affect his/her fitness for air travel or which may affect his/her need for oxygen, please complete Section 2. Otherwise, sign and date this form.

**Advance Notice Required**

* North America: 48 hours
* International: 72 hours
* POC or CPAP: 48 hours
Best efforts will be made to accommodate requests made within this delay.

______________________________  __________________________
Physician Signature        Date
Passenger’s Name:  
Booking Ref.:  

SECTION 2 – DECLARATION OF ILLNESS, ACCIDENT AND/OR TREATMENT

1) a) Diagnosis: ____________________________________________  b) Date of Onset: _________________
   c) Treatment: ___________________________________________________________________________________
   d) Nature and date of any surgery:  __________________________________________________________________

2) Present symptoms and severity:   _____________________________________________________________________

3) Will a cabin pressure the equivalent of a fast trip to a mountain elevation of 2400 m (8000 ft) above sea level (i.e. a 25% reduction in the ambient partial pressure of oxygen) affect the passenger’s medical condition? □ Yes □ No

4) Can the patient walk 100 meters at a normal pace or climb 10-12 stairs without symptoms? □ Yes □ No

5) Medication list: __________________________________________________________________________________

6) Vital signs
   a) Oxygen saturation _____ % □ Room air □ O2 _____ Lpm  Blood pressure _______    Heart rate: _______
   b) Anemia □ Yes □ No  - Give degree in grams of hemoglobin: ____________

7) a) Is the patient medically fit to travel unaccompanied?
   □ Yes – For adults with cognitive disability, does the patient need assistance at the airport? □ Yes □ No
   □ No – The patient needs a safety/personal attendant to attend to personal needs (meals, toileting, administering medication, etc) AND to physically assist in the event of an emergency evacuation.
   Who should accompany passenger?
   □ Doctor □ Nurse □ Other adult (family, friend) able to attend to all personal AND safety needs
   
   b) Bowel Control: □ Yes □ No  Bladder Control: □ Yes □ No – Mode of control: ____________

8) Degree of ambulation:  Able to walk without assistance? □ Yes
   □ No  a) Wheelchair required for boarding □ To aircraft □ To seat
   b) Does the patient travel with his/her own wheelchair? □ Electrical □ Manual

9) Cardiac Condition
   a) Angina: □ No □ Yes  Date of last episode: ____________________________________________
   Limit to physical activity: □ None □ Slight □ Marked □ Severe
   b) Myocardial Infarction: □ No □ Yes - Date: ____________________________________________
      i) Complications: □ No □ Yes – Specify: ____________________________________________
      ii) Low risk on angiography or non-invasive studies? □ Yes □ No
      iii) If angioplasty or coronary bypass, date: _______________________________________
   c) Cardiac Failure: □ No □ Yes – Date of last episode: _______________________________________
   Functional class: □ No symptoms Short of breath: □ With major effort □ With light effort □ At rest
   d) Syncope: □ No □ Yes - Investigations: ____________________________________________
Passenger’s Name:  
Booking Ref.:  

SECTION 2 – DECLARATION OF ILLNESS, ACCIDENT AND/OR TREATMENT (Continued)

10) **Chronic Pulmonary Condition:**  
□ No  □ Yes  – Diagnosis:  

a) Short of breath:  □ No  □ On exertion  □ At rest  
b) Has the patient had recent arterial gases?  □ No  □ Yes  If yes, what were the results?  
  □ pCO₂  ___________ □ pO₂  ___________ □ Saturation  _______%  Date of exam:  ___________  
  Blood gases were taken on:  □ Room air  □ Oxygen  _______ LPM  
c) Has the patient recently taken a commercial aircraft in these same conditions?  □ Yes  □ No  
  If yes, any medical problems or complications?  ______________________________________________________

11) **Psychiatric/Behavioural/Cognitive Condition:**  
□ No  □ Yes  – Diagnosis:  ____________________________  

a) Is there a possibility that the patient will become agitated during the flight?  □ Yes  □ No  
b) Has he/she taken a commercial aircraft before?  □ Yes  □ No  
  If yes, did he/she travel:  □ Alone  □ Accompanied  Date of travel:  ___________

12) **Seizure:**  
□ No  □ Yes  

a) Cause/Type:  __________________________________________________  
  b) When was the last seizure?  ____________  
  c) Are the seizures controlled by medication?  □ Yes  □ No  

13) **Allergy to cats:**  Do you suffer from:  
□ itchy eyes  □ runny nose  □ itchy skin/rash  
□ wheezing  □ cough  □ shortness of breath  
  Do you carry your own asthma inhaler/pump?  □ Yes  □ No  

14) **Allergy to dogs:**  Do you suffer from:  
□ itchy eyes  □ runny nose  □ itchy skin/rash  
□ wheezing  □ cough  □ shortness of breath  
  Do you carry your own asthma inhaler/pump?  □ Yes  □ No  

15) **Other medical information:**  
___________________________________________________________________________________________

16) **Prognosis for a safe trip:**  
□ Good  □ Guarded  □ Poor  

___________________________________________________________________________________________  

Physician Signature  Date

Revised: December 23, 2013
PASSenger’s Name:  

Booking Ref.:  

SECTION 3 – EXTRA SEATING FOR REASON OF OBESITY

FOR ITINERARIES WHOLLY WITHIN CANADA ONLY

THIS SECTION REQUIRED ONLY IF REQUESTING AN EXTRA SEAT FOR REASONS OF OBESITY

The information provided herein will assist Air Canada in determining passenger’s right to accommodation in the form of extra seating without charge.

For first assessment, please ensure all sections above are completed by the attending physician.

If this is a renewal, this section can be completed by an occupational therapist, a physiotherapist or nurse practitioner provided no other co-morbidities had been identified by the physician in the initial assessment and passenger’s fitness for flying has not changed in the last 2 years.

1) **Measurements** (please use metric measurements)
   
   a) Weight ___________ kg  
   
   b) Height ___________ cm  
   
   c) Body Mass Index ______________ (kg/m²)  
   
   d) Surface measurement * A to B ___________ cm

* Surface measurement should be calculated by measuring the distance between the extreme widest projection points of the patient when seated as follows instruction:

1. Have your patient sit on a paper covered examination table.
2. Rest a ruler or straightedge on the left side of patient at the widest point (hip or waist) as shown on diagram below.
3. Mark the touch point between the ruler and the paper as Point A.
4. Rest a ruler or straightedge on the right side of patient at the widest point (hip or waist).
5. Mark the touch point between the ruler and the paper as Point B.
6. Measure the distance between Point A and Point B, and indicate this measurement above under “d) Surface measurement”.

_________________________  ______________________  
Physician Signature        Date

Call the Air Canada Medical Assistance Desk at 1-800-667-4732 and provide your booking reference in order to request extra seating for medical reasons and make any other necessary arrangements for your flight.
Passenger’s Name: 
Booking Ref.: 

SECTION 4 – TRAVELLING BETWEEN CANADA AND THE USA

For passengers traveling on a flight between Canada and the USA, we can only require the completion of this Section 4 of this FITNESS FOR AIR TRAVEL Form. However, we strongly recommend that Section 2 be completed by the attending physician to ensure that passengers’ condition will not be aggravated in a hypoxic cabin environment.

1) Reasonable Doubt

Will the passenger be able to complete the flight safely without requiring extraordinary medical attention?

□ Yes
□ No – for instance, the passenger:

a) Has an unstable medical condition;
b) Has a medical condition that may worsen in a hypoxic environment;
c) May require medical assistance during flight;
d) May require the use of onboard emergency medical equipment; or
e) Is unable to self-administer medications or routine medical care necessary to maintain the stability of his/her condition during a flight (e.g. insulin injection).

2) Communicable Diseases

a) Does the passenger have a disease or infection that, would under the present conditions, be communicable to other persons and that could pose a direct threat to the health or safety of others during the normal course of the flight?

□ No □ Yes

b) Are there any conditions or precautions that would have to be observed to prevent the transmission of the disease or infection to other persons in the normal course of the flight?

□ No □ Yes

If so, state which: __________________________________________________________

3) Oxygen

Does the passenger use oxygen on the ground, or will the passenger require supplemental oxygen in flight?

□ No □ Yes – Please complete Section 1

________________________________________________________________________

________________________________________________________________________

Physician Signature Date*

*Must be dated within 10 days of the date of the initial departing flight

Revised: December 23, 2013