



Follow-up Request Forms

(Complete Set)

HALF THE CURE IS GETTING THERE!



Follow-up Request Form

*** This page is for follow-up trips after receiving the initial paperwork. ***

*** Patient under the age of 18 must be accompanied by a parent or adult guardian. ***

*** The patient is responsible for making his/her own accommodations for ground transportation. ***

Date: _____ **Patient's Record # (if any)** _____ **Date of Birth:** _____

Patient's Name: _____ **Weight (lbs):** _____

Home Number: _____ **Cell Phone:** _____

Primary Language Spoken: _____ **If other than English, whom do we contact?**

Contact Name: _____ **Phone number:** _____

*****If the patient's condition has changed due to surgery, hospitalization, etc. a new Physician's Letter must be sent along with this form. ***** **Patient's Condition:** ___ Unchanged ___ Changed

Travel Date: _____ **Appointment Date:** _____ **Appt Time:** _____

(1000-mile limit) Origination City: _____ **Destination City:** _____

Return Date: (if applicable): _____ **Release Time:** _____

Place of Lodging: _____ **Phone number:** _____

1st Passenger (other than patient): _____ **DOB:** _____

Relationship to patient: _____ **Weight (lbs):** _____ **Height:** _____ ft. _____ in.

2nd Passenger (only if patient is a child): _____ **DOB:** _____

Relationship to patient: _____ **Weight (lbs):** _____ **Height:** _____ ft. _____ in.

Will the patient be taking: Crutches: Y/N Oxygen: Y / N Oxygen _____ (lbs) **Must be small aluminum canisters**

Wheelchair: Y/ N **If yes, weight (lbs):** _____ **Dimensions:** _____ **Must be collapsible**

Total Baggage Weight: _____ **NOT TO EXCEED 50 LBS!**

Name of Qualifying Person (Doctor, Nurse, Social Worker, Etc.): _____

Signature of Qualifying Person: _____

Qualifying Facility _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Pager:** _____ **Fax:** _____

Email: _____

*****THIS PAGE MUST BE COMPLETED BY A QUALIFYING PERSON (Doctor, Nurse, Social Worker etc, not by the patient) & FAXED (972) 858-5492 TO THE GRACE FLIGHT OFFICE *****



Physician's Letter

Your patient has requested assistance with transportation for his/her medical needs. In order for this to occur, please print your name and sign this form to confirm that this patient can safely fly using our services.

(Patient's Name) _____ is a patient in my care who requires transportation for the following reasons: _____

_____ a
nd is medically stable, ambulatory and physically able to enter and exit a small, light, non-pressurized aircraft and does not have any medical condition that could affect either the safety of the flight (taking into account such conditions as seizures and medical disorders or any medical equipment) or his/her personal health and safety during the flight.

Physician Name: (Please type or print) _____ **Date:** _____

Physician Signature: _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

**** IS YOUR FACILITY HIPAA COMPLIANT? YES _____ NO _____**

Note to the Physician:

The cabin of a small aircraft can be smaller than the inside of a small vehicle, and in certain aircrafts the passenger will be seating alongside the pilot with close proximity of the flight controls and switches. Your patient should have a legitimate need for medical treatment not available locally and should also need to avoid lengthy surface transportation. Please give Grace Flight up to **7 business days (Monday – Friday)** notice or more to locate volunteer pilots to make the mission; many are business people who must rearrange their schedules to fit the needs of your patient.

**THIS PAGE MUST BE COMPLETED AND FAXED BACK
TO THE GRACE FLIGHT OFFICE (972) 858-5492.**