Effective
March 31, 2010

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:___________________________________

Patient's Illness: ____

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

(1000-mile limit) Origination City:__________________________ Destination City: ____________________________

Travel Date: _____________________ **Appointment Date:** _____________________ **Appt Time:** ______________

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 BACK TO THE OFFICE** ***(972) 858-5492.*** *******

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: ____

____

and is medically stable, ambulatory and physically able to enter and exit a small, light, non-pressurized aircraft (generally 4-6 seats). The patient does not have any medical conditions 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 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 BY THE PATIENT'S DOCTOR**
(*not by the patient*) & FAXED BACK TO THE OFFICE *(972) 858-5492.* **