



Medical Request Forms

(Complete Set)

HALF THE CURE IS GETTING THERE!



User Instructions

To better coordinate the process of transporting patients to their medical care treatments/appointments, please use the following guidelines. These guidelines should ensure a smoother process of fulfilling our main objective - providing transportation for the patients - with the least amount of stress on all parties involved (the patient, you, and Grace Flight). Thank you.

1. The enclosed forms are your **master copies**. Make copies for each mission. Please keep for future use.
2. Send copies of completed forms to the Grace Flight office by fax to (972) 858-5492. These pages must be received before flights can be coordinated.
 - a. Mission Request Form
 - b. Physician's Letter
 - c. Guidelines Form
 - d. Patient Guidelines
3. The **Follow-up Request** form is for any follow-up flight after the initial paperwork is completed. If the patient's condition has changed due to surgery, hospitalization, etc. a new Physician's Letter must be sent.

MISCELLANEOUS INFORMATION:

4. The patient must have a legitimate medical need to use our services.
5. Patients **must be ambulatory**. Grace Flight uses non-pressurized small private planes (generally 4-6 seats) to transport passengers. The patient must be able to walk and get in and out of a plane with limited assistance. This can mean stepping up onto the wing (16-20 inches above the ground) and lowering themselves into the back seat.
6. We **don't** transport unaccompanied minors. Patients 18 yrs. old and younger must be accompanied by a parent or an adult guardian.
7. We have a **1000 mile limit** from starting city to destination city.
8. **On flights less than 300 miles**, we need **5** business days (Monday – Friday) notice for the request.
9. **On flights over 300 miles**, we need **7** business days (Monday – Friday) notice for the request.
 - a. We **can't** fly patients in and fly them home the same day as the appointment.
 - b. If they want to fly in the same day of the appointment, the appt. must be after 3PM and fly home the next day.
 - c. If they want to fly home on the same day as their appt., must be ready to depart from the airport no later than 11AM.
 - d. If the patient doesn't meet the requirements above, must fly in the day before the appt. and fly home the day after the appt.
10. Aircrafts have **weight & balance limits**. Please inform patients and passengers that baggage is limited to a total of **50 pounds for all persons traveling**.
11. **No balloons** may be taken on the airplane as they will burst at altitude.
12. Pilots will contact the patients directly to coordinate pickup time and location. **The patient is responsible for making his/her own accommodations for ground transportation.**
13. Wheelchairs and/or oxygen (sm. canisters) are allowed upon approval by Grace Flight. Please advise the Grace Flight office of these special equipment needs. We don't provide such equipment/medical personnel for travel.
14. Patients and passengers will be asked to sign liability release forms for pilots and for Grace Flight before takeoff. These must be signed before the pilot can fly the patient.
15. Under rules, the pilot is responsible for the safety of the flight. Grace Flight coordinates between pilots and patients but assumes no responsibility for the qualifications/performance of the pilot or the airworthiness of the aircraft.
16. Pilots make final decisions about the missions. A pilot may delay/cancel a mission. In the event of weather, critical safety factors, or in the event the patient makes any changes, that weren't informed to the Grace Flight office.

THIS PAGE IS FOR INFORMATION ONLY, DO NOT FAX BACK



Mission Request Form

*****Patients under the age of 18 MUST be accompanied by a parent or adult guardian*****

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

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

Patient's Address: _____

City: _____ **State:** _____ **Zip:** _____ **County:** _____

Phone: _____ **Work phone:** _____ **Fax:** _____

Cell: _____ **Email:** _____

Patient's Illness: _____

Patient's Place of Employment (if patient's is a minor, parent's place of employment): _____

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

Name: _____ **Phone number:** _____ **Cell:** _____

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

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

Return Date: _____ **Release Time:** _____

Patient's Place of Lodging: _____ **Lodging Phone:** _____

Requesting Agency (The facility where the requester works at): _____

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

Requester (Doctor, Nurse or Social Worker filling out the paperwork): _____

Requester's Phone #: _____ **Requester's Fax:** _____

Requester's Pager: _____ **Email:** _____

Patient's Doctor: _____ **Phone:** _____

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

Treatment Facility at Destination: _____ **Phone:** _____

Doctor at Destination: _____ **Phone:** _____

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!**

*****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. ****



Grace Flight Guidelines

A patient must meet the following criteria before being referred for air transportation.

Qualifying Person: *If the patient isn't there when you're filling out the paperwork, please call the patient and read this verbally to the patient. Your signature indicates the patient meets and fully understands our guidelines.*

Patient or Legal Guardian: *Your signature indicates you understand our guidelines.*

1. The patient/passengers traveling **must be ambulatory** and must have a legitimate medical need to use our services.
2. Grace Flight uses small, non-pressurized private planes (generally 4-6 seats and not equipped for medical emergencies) to transport our passengers. All passengers must be able to walk and get in and out of the plane with limited assistance. This can mean stepping up onto the airplane wing (16-20 inches above the ground) and lowering themselves into the back seat.
3. We do not transport unaccompanied minors. Patients 18 years old and younger must be accompanied by a parent or an adult guardian.
4. No one can fly on the flight that was not on the original request. The number of passengers and their weight are factors when planning the flight. For safety reasons, luggage must be kept to 50lbs (**Total for All Passengers**). Please use soft-sided luggage. No bigger than a carry on bag. If you have any other items, please notify our office immediately (i.e. stroller, car seat, walker, oxygen etc.) **Weight in a small aircraft is extremely critical.**
5. Anyone traveling with a child who is younger than 5 years old or less than 36" in height you must provide a safety seat. **If you are traveling to or within TEXAS, with a child who is younger than 8 years old or less than 57" in height you must provide a safety seat.** We don't provide a safety seat.
6. The Patient/Passengers must have a back up plan for the outgoing **and** return trip or the ability to reschedule an appointment in the event the flight must be canceled due to weather or any other reason. We **do not** guarantee a flight(s) will be scheduled, due to the fact that all of our pilots are volunteers.
7. Please keep us inform of any changes (972) 755-043 (**Companion change, appointment canceled, made other arrangements, lodging info, baggage etc.**) If you find other means of transportation prior to your flight date please notify our office **immediately**. Any changes not agreed to prior to the flight will not be accommodated. **For after hour emergencies call the office and listen to the recording to get the number to reach the On-Call Coordinator.**
8. **The patient/passenger is responsible for making his/her own lodging and ground transportation arrangements.**
9. Once the pilot(s) has made the arrangements to meet, it's essential that the patient/passengers be on time. It's important that the pilot stay on schedule he/she filed with the Federal Aviation Administration and with the handoff pilot should there be one on the trip.
10. The patient/passengers can't call any pilots who have flown them on previous Grace Flight as it breaches our privacy agreement. A qualifying person must make the flight requests. (Doctor, nurse, social worker etc.)
11. Failure to comply to any of the above guidelines **WILL** jeopardize any future flight with Grace Flight.
12. **The patient will be required to sign a waiver of liability releasing Grace Flight and the pilot from any liability.** This form will be with the pilot and must be signed prior to departure.

Patient or Legal guardian's Signature: _____ **Date:** _____

Signature of Qualifying Person: _____ **Date:** _____

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(Doctor, Nurse Social Worker etc.) & FAXED BACK TO THE OFFICE (972) 858-5492. *****



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. *****