Mission Guidelines Form

Rev 6/17

Patient's Name: _____ Date:_____

Caller name, phone # & relationship to patient: _____

_____

To be considered for free air transportation, please check all of the following that apply

_____ The necessary medical care/ second opinion/ specialist is not available locally

_____ Car travel is too difficult / time consuming

_____ Patient cannot afford alternative travel costs

_____ Patient is not able to travel on public transportation due to condition / immune deficiency

All patients must agree to and understand to the following before being accepted for free air transportation:

_____ Patient is able to walk & climb stairs (unless the patient is a child under 6 years old and can be carried)

_____ Patient will provide physician name, address, phone and fax number

_____ Patient is able to ride in a small plane with NO bathroom

_____ Patient is responsible for ground transportation to and from airports

_____ Patient agrees not to exceed weight given. Personal belongings must be in a soft sided bag.

_____ Patient will not wear colognes or perfumes on day of flight

_____ Wheelchairs or strollers are not permitted on plane with the exception of collapsible umbrella strollers

_____ Each adult must sign a waiver for themselves and minors, that will be provided by volunteer pilot at airport before boarding

_____ Patient agrees to give handwritten thank you note to pilot

_____ Patient allows Angel Flight Soars to share patient information with sister organizations as needed to coordinate mission

_____ Patient acknowledges that weather can cause the mission to be canceled and will have other transportation available or be able to reschedule flight

_____ Patient will call if he/she makes other travel plans or appointment date/time changes

_____ _____

Patient Signature **Date**