Dear Doctor or Medical Professional:

We need your quick assistance with this request because one of your patients asked us to fly him/her to medical treatment needed at a distant medical facility. Please help your patient by completing the Medical Release Form below and returning it to us quickly.

Mercy Flight™ Southeast is a nonprofit, charitable volunteer pilot organization. We utilize a network of volunteer pilots to provide **free** air transportation to those in medical and financial need. Our pilots donate their time, planes and fuel to transport patients to distant medical facilities when commercial transportation is not available, impractical or simply not affordable. Our pilots do not get reimbursed for their costs. **So, it is imperative that our very limited resources go to those truly in need.**

A patient must meet the following qualification criteria for us to try to schedule a mission:

- **Patient must be medically stable.** The patient must be able to travel in small aircraft at ambient pressure altitudes of up to 8,000 feet. We are not an air ambulance service nor are we allowed to transport medical personnel on our flights. We are able to take those who bring their own oxygen. Should a patient need an air ambulance we have referral agencies on file.
- **Patient must be ambulatory.** We do not use large jets. Most of our planes are 4 or 6 seat unpressurized aircraft. Therefore, the patient must be able to walk, climb in and out of a small plane by stepping up 16 to 20 inches with limited assistance, bend over to enter and exit the aircraft, lower themselves into the back seats, be able to sit upright, and wear a seatbelt for the duration of the flight.
- **Treatment can not be available locally.** There must be a significant reason why the patient needs to go to a distant medical facility instead of getting the treatment locally.
- **Treatment must not be unconventional.** The patient’s treatment must be considered conventional treatment or authorized investigational protocols. If in doubt, contact us.
- **Patient must have a financial need or significant reason to use our services.** We are not in operation to give free plane rides to anyone who would like a flight, and we need to be sure our resources are going to those who truly need them. Therefore, we look to you, as a medical professional who knows the patient, to assist us in our screening process. If you believe the patient has the ability to purchase a commercial airline ticket to get to their medical treatment, we ask that you state that on the Medical Release Form below so we can investigate that aspect further. If the patient cannot fly on commercial aircraft due to his/her illness, we waive our financial need qualification but must make sure that you believe it will be safe for your patient to fly on our small unpressurized aircraft.

Please call us immediately if you have any questions or concerns about our services or your patient utilizing our services. We are here to help you help your patient.

Please complete and sign the attached Medical Release Form and fax back to us ASAP. Your patient’s mission will **not** be scheduled until we receive this release from you.

Sincerely,

Mission Control
Medical Release Form - Mercy Flight™ Southeast

A. Information Mercy Flight™ Southeast has about patient and the proposed mission:

Patent’s Name: ____________________________________________
Patient’s Address: ____________________________________________
Patient’s City/State/Zip: ____________________________________________
Patient’s Date of Birth: ____________________________________________
Patient’s Weight: ____________________________________________
Patient’s Specific Diagnosis: ____________________________________________
Patient’s Need for Our Services: □ Financial Need  □ Lives in a Remote Area  □ Weaken Immune System  □ Other: ____________________________________________
Local Doctor: Name: ___________________________  Tel #: ___________  Fax #: ___________
Treatment Dr: Name: ___________________________  Tel #: ___________  Fax #: ___________
Outbound: Date ___________  Origination City & State: ____________________________
Returning: Date ___________  Destination City & State: ____________________________

B. Medical Professional Response When Familiar With Aviation Physiology

Complete this section if you are sufficiently familiar with aviation physiology to be able to make a recommendation about whether or not your patient can travel in small aircraft at ambient pressure altitudes of up to 8,000 feet.

□ Yes  □ No  Do you believe your patient is medically able to fly with Mercy Flight™ Southeast?
If No, please explain ____________________________________________

□ Yes  □ No  Do you believe your patient meets the qualifications shown in our cover letter to you?
If No, please explain ____________________________________________

Printed Name: ____________________________
Signed: ____________________________  M.D./D.O.  Date: ___________

This authorization will be valid for 90 days unless you indicate otherwise.

If you completed Section B, please fax only page 1 of this Medical Release Form with a fax cover sheet to: Mercy Flight™ Southeast, Inc.  Fax #352-326-9360  Phone #352-326-0800
Our fax is dedicated and secure.
C. Medical Professional Response When Not Familiar With Aviation Physiology

Complete this section, to the extent possible, if you are not sufficiently familiar with aviation physiology to be able to make a recommendation about whether or not your patient can travel in small aircraft at ambient pressure altitudes of up to 8,000 feet, and you request that Mercy Flight™ Southeast rely upon the opinion of the aero-medical liaison physician with regard to flying this patient. Your responses will assist our aero-medical liaison officer in making tactical decisions about whether or not the patient should be considered for a mission with us. Our aero-medical liaison officer may call you to ask for more details if necessary to support his evaluation.

1. What is the hemoglobin and/or hematocrit? ________________________________

2. □ Yes □ No Is there any compromise to the respiratory process?
   If YES, please specify _____________________________________________________

3. □ Yes □ No Is there any inflatable device in place?
   If YES, please specify _____________________________________________________

4. □ Yes □ No Does patient have any disorder that might predispose to disruptive or violent behavior?
   If YES, please specify _____________________________________________________

5. □ Yes □ No Does patient pose any risk of contagion to others in close proximity?
   If YES, please specify _____________________________________________________

6. □ Yes □ No Is there any element of intestinal obstruction?
   If YES, please specify _____________________________________________________

7. □ Yes □ No Is there any history of middle ear problems?
   If YES, please specify _____________________________________________________

8. □ Yes □ No Are there tympanic membrane perforations or ventilating tubes present?
   If YES, please specify _____________________________________________________

9. □ Yes □ No Is there need for any special supportive equipment?
   If YES, please specify _____________________________________________________

10. □ Yes □ No Do you believe your patient meets the qualifications shown in our cover letter to you?
    If No, please explain ____________________________________________________

Provide any other helpful information here: ______________________________________
________________________________________________________

Printed Name: __________________________________________________________________

Signed: _______________________________ M.D./D.O. Date: _____________

If you completed Section C, please fax only pages 1 and 2 of this Medical Release Form with a fax cover sheet to: Mercy Flight™ Southeast, Inc. Fax #352-326-9360 Phone #352-326-0800 Our fax is dedicated and secure.