Mercy Flight™
SOUTHEAST

8864 Airport Blvd., Leesburg, FL 34788
Phone Nbr. 352-326-0800
Fax Nbr. 352-326-9360

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.

Medical Release Form - Mercy Flight™ Southeast

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.