FIT TO FLY FORM

PATIENT_____

DIAGNOSIS_____

Weight and height of the patient _____/___

RECOMMENDATIONS ON REPATRIATION:

1. He / she fit to fly by regular flight since: __ / __ /_____

☐ **Yes** ☐ **No**

2. Position durinng the flight (please outline appropriate option):

☐ **seated** ☐ **ample seat / first row / business class**
☐ **on stretcher** ☐ **extra-seat**
☐ **rest leg**

3. Type of transport immobilization (please outline appropriate option):

☐ **none** ☐ **arm cast** ☐ **short leg cast / below knee**
☐ **corset** ☐ **cruro-pedal cast** ☐ **long leg cast / above knee**
☐ **pelvic-pedal cast** ☐ **knee orthoses / braces**

4. Escort during transportation (please outline appropriate option):

☐ **none** ☐ **non-medical** ☐ **nurse** ☐ **doctor** ☐ **nurse+doctor**

Signature: Date: