MISSION REQUEST FORM

(PAGE 1)

Patient # ______
In ____________
Home __________
(For office use only)

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

Date: __________ Patient's Record No.________ Gender: ________ Date of Birth _____________

Patient's Name: ___________________________Weight (lbs.): ____________ Height: ___________

Patient's Address: ____

City: _________________________ State: ______ Zip: ___________ County: _____________________

Phone: ___________________________ Work phone: _____________ Fax: _______________________

Cell: ________________________ Email: ____

Emergency Contact: ______________________________ Phone ________________________________

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

Name: _________________________________ Phone number: _____________ Cell: _______________

Origination City: __________________________ Destination City: ______________________________

Travel Date: ___________________ Appointment Date: _____________ Time: ________________

Return Date: __________________ Release Time: ____

Patient's Place of Lodging: _____________________ Lodging Phone: _______________________

Requesting Facility: ____

Address: _______________________ City: ________________________ State: ______ Zip: ___________

Requester: ______________________________ (Case Worker) Phone #:__________________________

Case Worker Pager: __________________ Case Worker Email: _________________________________

Patient's Doctor: _________________________ Phone: _________________________________

Address: _______________________________ City: __________________ State: _____ Zip: __________

Patient's Medical Condition: ____

DIAGNOSIS IN LAYPERSON'S TERMS: ____

Is the patient: Veteran ___________ Employed ___________ On Public Assistance ___________

Companions flying with the patient must meet the same criteria as the patient with regard to their health. They must be ambulatory, medically stable, and weigh less than 250 lbs.

BOTH PAGES MUST BE COMPLETED BY A QUALIFYING PERSON
***(Doctor, Nurse Social Worker etc.)* & MAILED OR FAXED TO:**

Pilots For Patients
3127 Mercedes Dr. Monroe, LA 71201
Phone (318) 322-5112 -- Fax (318) 388-4924

MISSION REQUEST FORM

(PAGE 2)

Patient's name ____

Treatment Facility at Destination: ___________________________ Phone: _____________

Doctor at Destination: _________________________ Phone: ________________________

Passenger (other than patient): _____________________________ Weight: ______ DOB: _________

Relationship to patient: ______________________________________ Phone: ______________________

Does the patient meet guidelines? Y / N Is patient ambulatory? Y / N

Crutches? Y/N

Will the patient be taking oxygen? Y / N Weight of Oxygen (lbs.) _________

Must be small aluminum canisters

Weight of all baggage: ________ **NOT TO EXCEED 50 Lbs.!**

The maximum number of bags is 2 and no larger than 12" x 18" x 24"

While we strive to find a pilot for each request, all patients are encouraged to have a backup plan should we be unable to fill their flight requests.

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