COMPAGNIE D'ASSURANCES
VERSICHERUNGS – GESELLSCHAFT
INSURANCE COMPANY

FIT TO TRAVEL FORM

To be completed by the treating doctor in charge of the patient

PATIENT'S DATA

Name/Surname:	**Weight:**
Date of birth:	**Height:**

LATEST VITAL VALUES:	**DIAGNOSIS**
O2 Sat: ……. T°:……	
BP:……. Pulse:……	
Hemoglobin:	
	If appropriate: date and type of intervention

TRANSPORT RECOMMENDATIONS

AIR TRANSPORT ☐ Regular flight ☐ Extra seat(s) ☐ Business

Patient must remain seated at least 45min for take-off and landing

☐ Stretcher (lying and immobilized transport)

☐ Sanitary Jet/ Air ambulance ☐See level

MEDICAL ESCORT ☐ None ☐ Non-medical ☐ Nurse ☐ Doctor ☐ Doctor and Nurse

GROUND TRANSPORT ☐ Ambulance: ☐ Basic ☐ Intensive (Doctor/Nurse or Anesthetist)

☐ Limo ☐ Taxi

☐ Driver needed ☐ Can drive own car

WHEELCHAIR ☐ WCHR ☐ WCHS ☐ WCHC

If Patient uses own wheelchair, please precise following data:

☐ Regular ☐ Electric if electric, please precise name of the battery ……

☐ Brand:……☐ Weight……☐ Measures(LxWxH)……

MONITORING AND DEVICE

OXYGEN: ……l/min ☐ continuous flow ☐ intermittent flow

VENTILATION : ☐ Non-Invasive (CPAP, BiPAP) ☐ Invasive (ventilation mode) ……

Tidal volume/IA……Respiration rate:……PEEP:…… FiO2……

VASOACTIVE DRUG : ☐ Type/Dose……

MONITORING : ☐ Peripheral venous catheter ☐ Arterial line

☐ Central venous line ☐ Invasive pressure monitoring

RENAL : ☐ Bladder Catheter ☐ Dialyze needed during transport/on arrival

ORTHOPEDICS: ☐ Vacuum mattress ☐ Traction/external fixation

☐ Splint/Cast/Neck brace *Cast needs to be split to be air transport compatible*

OTHER DRUG(S) NECESSARY OR MATERIAL NEEDED DURING TRANSPORT:

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DESTINATION **☐ OUTPATIENT/HOME** **☐ HOSPITAL**

THE PATIENT IS FIT TO TRAVEL SINCE:	**DOCTOR'S NAME (AND STAMP)**
……	
DATE (DD/MM/YY) :	**DATE (DD/MM/YY) :**

Please send this form to operations@tsm-assistance.com or by Fax: +41 22 819 44 99