HOPE AIR

Travel Request Form

Email we should follow up with: _____

A PATIENT INFORMATION

Has patient used Hope Air before?	☐ YES	☐ NO
Is appointment covered by provincial health plan?	☐ YES	☐ NO
Does Patient have valid, non expired government issued ID?	☐ YES	☐ NO
Does patient have diabetes?	☐ YES	☐ NO
If yes type 1, type 2, or other?	☐ TYPE 1	☐ TYPE 2 ☐ OTHER

PATIENT NAME (MR/MS/MRS/MISS/MASTER):
*MUST BE SAME AS ON TRAVEL ID

DATE OF BIRTH:

PATIENT TELEPHONE:

ALTERNATE TELEPHONE:

EMAIL:

PATIENT MEDICAL CONDITION:

NAME OF REFERRING DOCTOR IN HOME CITY:

PHONE NUMBER OF REFERRING DOCTOR IN HOME CITY:

HOUSEHOLD ADDRESS:

B REQUESTOR INFORMATION

NAME:

WORK NUMBER:

CELL NUMBER (OPTIONAL):

EMAIL:

WHO TO CONTACT IN FOLLOW UP:

C ESCORT INFORMATION

NAME (MR/MS/MRS/MISS/MASTER):
*MUST BE SAME AS ON TRAVEL ID

DATE OF BIRTH:

PHONE NUMBER:

RELATIONSHIP TO PATIENT:

D HOUSEHOLD INCOME

Number of adults and children in household

ADULTS:

CHILDREN:

Please enter below: Name of each household member, and each source of income each person receives, gross annually (i.e. Lisa, full time employment $30,000. Bill, old age security pension, $5,000)

MEMBER 1:

MEMBER 2:

MEMBER 3:

MEMBER 4:

MEMBER 5:

MEMBER 6:

CHILD BENEFIT, SUPPORT PAYMENTS, ETC. FOR CHILDREN:
*PLEASE INDICATE MONTHLY OR YEARLY

E REQUESTING TRAVEL DATES/FLIGHT REQUIREMENTS

Please note: If the appointment is a surgery, procedure, or appointment where a return date cannot be confirmed, a one way flight will be booked. A return flight will be booked when you call us, and provide confirmation from the Dr. that you are fit to fly home.

DEPARTURE CITY:

ARRIVAL CITY:

DEPARTURE FLIGHT DATE:

DEPARTURE FLIGHT PREFERRED TIME (MORNING, AFTERNOON EVENING):
*NOT GUARANTEED, BASED ON AVAILABILITY AND ROUTE

RETURN FLIGHT DATE:

RETURN FLIGHT PREFERRED TIME (MORNING, AFTERNOON EVENING):
*NOT GUARANTEED, BASED ON AVAILABILITY AND ROUTE

Oxygen, wheelchair, physical assistance at airport required? ☐ **YES** ☐ **NO**

F APPOINTMENT INFORMATION

BEGINNING OF MEDICAL TREATMENT DATE / TIME / DURATION:

IF PATIENT HAS A SERIES OF APPOINTMENTS, WHEN IS THEIR LAST APPOINTMENT DATE/TIME/DURATION?

TYPE OF APPOINTMENT (I.E. ASSESSMENT, SURGERY, FOLLOW UP):

TREATING DOCTOR NAME:

HOSPITAL OR CLINIC NAME AND / OR LOCATION:

PHONE NUMBER OF TREATING DOCTOR'S OFFICE:

G RETURN FLIGHT HOME (ONLY APPLICABLE IF PATIENT WAS AIR AMBULANCED)

DATE WHEN PATIENT WAS AIR AMBULANCED:

H ACCOMMODATION REQUEST (5-NIGHT STAY ONLY – HOTEL PARTNERSHIP)

Request Accommodations?
*Yes – please answer the following questions ; No – Please proceed section H

☐ **YES** ☐ **NO**

Dates Match Travel Dates?
*If No please enter the alternative check in and check out dates

☐ **YES** ☐ **NO**

ALTERNATIVE CHECK IN DATE:

ALTERNATIVE CHECK OUT DATE:

How many People staying?

Names of Guests

GUEST 1:

GUEST 2:

GUEST 3:

GUEST 4:

GUEST 5:

GUEST 6:

I SURVEY QUESTIONS

ALTERNATIVE METHOD OF TRAVEL IF HOPE AIR IS NOT ABLE TO ASSIST:
(I.E. GROUND TRANSPORTATION, CANCEL APPOINTMENT, BORROW MONEY TO PURCHASE FLIGHT)

Would you like to subscribe to Hope Air Newsletters? ☐ **YES** ☐ **NO**

J VACCINE DATES

*Please provide second dose date for passengers over 12 years old below

PASSENGER 1:

FULL NAME:

DATE OF SECOND VACCINATION:

PASSENGER 2:

FULL NAME:

DATE OF SECOND VACCINATION:

PASSENGER 3:

FULL NAME:

DATE OF SECOND VACCINATION:

PASSENGER 4:

FULL NAME:

DATE OF SECOND VACCINATION:

PASSENGER 5:

FULL NAME:

DATE OF SECOND VACCINATION:

PASSENGER 6:

FULL NAME:

DATE OF SECOND VACCINATION: