

This sheet is detail questions for [PART ONE(2)] No.13.

1 Cardiac condition

- a. When was last episode? _____
- b. Stable condition Yes No
- c. Is this patient controlled with medication? Yes No
- d. Functional class (NYHA class) Class I Class II Class III Class IV
- e. Complications Yes No If yes, give details _____
- f. Last EKG When _____ Result _____
- g. Stress EKG (Treadmill test) When _____ Result _____
- h. Echocardiogram When _____ Result _____ EF: _____ %
- i. Angioplasty / Coronary bypass When _____ Result _____
- * Please note or attach for f.g.h.i.'s result.

2 Respiratory condition

[25% to 30% reduction in the ambient partial pressure of oxygen in flight]

- a. How much oxygen needed in flight? _____ L/min Continuous Intermittent
- b. Mask type Nasal cannula Facial mask Bag valve mask
 Reservoir oxygen mask Other _____
- c. ABGA or O2 Saturation When _____ Result : P_{CO2} _____ PO₂ _____ Sat _____
Blood gases were taken on Room air Oxygen _____ L/min
- d. Has this patient's condition deteriorated recently? Yes No
- e. Can this patient walk 100 metres at a normal pace without symptoms? Yes No

3 Cancer condition

- a. Stage _____
- b. Has the patient had Chemotherapy or Radiotherapy Yes No If yes, when? _____
- c. Metastasis Yes No If yes, where? _____
- d. Pain control Yes No If yes, how? _____
- e. DNAR(Do Not Attempt Resuscitation) Yes No

4 Trauma

- a. The reason Motor vehicle accident Fall down Burn Other _____
- b. Traumatic brain injury Yes No If yes, give details _____
- c. Brain CT When _____ Result _____
- d. Internal organ injury Yes No If yes, give details _____
- e. Thoracic/Orthopedic injury(fracture) Yes No If yes, give details _____

5 Neurological deficit

- a. Location and status (give details) _____
- b. Motor power grade Upper extremity / Lower extremity /

6 Psychiatric disorder

- a. Is there a possibility that this patient will become agitated during flight? Yes No
- b. Is there a possibility to injury oneself or other? Yes No

7 Seizure disorder

- a. Seizure type _____
- b. Frequency/Duration _____
- c. When was the last seizure? _____
- d. Are the seizures controlled by medication? Yes No

Signature _____ Date _____