International Organization for Migration (IOM)
The UN Migration Agency

Medical Report and Assessment of Travel Fitness

Dear Doctor,

This form is to facilitate the voluntary return of migrants with health conditions by establishing that they are fit to travel, and their travel requirements are met. IOM physicians will base their decision to travel on your recommendation as well as on IOM standards. **Please return the completed document back to the return counsellor in charge of the case**, at the address below:

Address:	

Please note that the airline might request an additional form, which we will send you if it is needed.

More information on **IOM Bern's project for voluntary return flights** (available in German and French) on our website switzerland.iom.int

Physician name:	
Date and place:	
Physician signature:	

Patient Consent for Disclosure of Medical Information

Patient full name: ☐ Mr. ☐ Ms.

Patient date of birth:

I hereby authorize the above-mentioned physician to disclose to IOM the medical information described in this request and its attachments for the purposes of organizing my assisted voluntary return to my country.

Date and place:

Patient signature:

The information provided in this form and related annexes is considered confidential and limited to transfer information of the patient's health condition (diagnosis, treatment and advice on travel) to the Migration Health Division (MHD) of the International Organization for Migration (IOM), for the purpose of ensuring the safe travel of the patient and continuity of care.

Upon sending these documents to IOM:

- *IOM certifies that the information received will be strictly used for the purposes of medical evaluation for travel and arranging post-arrival care.*
- *The physician or healthcare professional is responsible for the assessment provided at the moment of the patient's health evaluation only, and by completing these documents he/she certifies that the information contained in the form and its annexes is accurate and complete to the best of his/her knowledge.*

PRINT FORM

MANUAL SIGNATURES REQUIRED ON THIS PAGE

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PART A: Medical Report

It is mandatory to complete Part A, pages 1-3 unless a separate full medical report is provided.
If this is the case, please confirm: ☐ I confirm a separate full medical report is attached
And then continue to Part B, page 4

A1. Diagnosis

A2. Brief medical history (relevant for travel, post-arrival re-integration or continuity of care)

☐ No history available

A3. Vital signs:

Mandatory for the following categories of patients: elderly, advanced/terminal stages of diseases, cardiovascular, respiratory, renal, blood diseases including anemia, and other, as per clinical judgement. Please provide actual measurements; if not measured, write "ND" (not done).

a. Temperature (°C)		d. Oxygen Saturation	0.00%
b. Blood pressure (MmHg)		e. Respiratory rate	
c. Pulse rate per min			

Date of measurement

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A4. Major findings at physical examination

Date of examination ☐ None

A5. Relevant laboratory results

☐ Not Applicable ☐ If applicable, please attach laboratory result sheet

A6. Current treatment, including names of drugs and dosages (or attach a separate sheet / prescription)

☐ No current treatment ☐ No prescribed medication

A7. Recommendations for follow-up treatment: including timeline ("immediately", "within X days/months")

☐ No follow-up required

Please continue to Part B

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The UN Migration Agency

PART B: Fitness to Travel and Travel Arrangements

It is mandatory to complete this section in all cases

B1. Are there any manifested medical reasons that obviously limit the patient's ability to make his / her decision on his / her return?

☐ No ☐ Yes (please include the corresponding report)

Remarks:

B2. In your medical opinion, is the patient fit to travel in his / her condition at the moment of the health evaluation?

☐ Yes (complete question B3) ☐ No (complete question B4) ☐ In doubt (include remarks below)

Remarks:

B3. If the patient is fit to travel, does he / she need to be accompanied during the flight?

☐ Yes (specify type of accompaniment in next questions) ☐ No

B4. If the patient is not fit to travel, how can the patient be stabilized for travel? Specify below

B5. Does the patient require assistance with feeding, toilet or communication (e.g. hearing / vision problems)?

☐ No ☐ Yes (specify below)

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The UN Migration Agency

B6. Does the patient have any of the following mobility problems? Please check all that apply

- ☐ The patient does not have any mobility problems

- ☐ Cannot sit for take-off / landing (30 minutes): needs stretcher
- ☐ Can sit for take-off / landing but needs to lie down during flight: business class seat
- ☐ Cannot walk within the aircraft: needs wheelchair to seat
- ☐ Can walk within the aircraft, but has difficulties taking stairs: needs wheelchair to cabin
- ☐ Mobile, but gets tired easily: needs wheelchair
- ☐ Other (please specify):

B7. Recommended travel arrangements. Please check all that apply

- ☐ Does not require any special arrangements
- ☐ Diabetic meal
- ☐ Mobility: Wheelchair (as per B6)
- ☐ Mobility: Business class or seat row (as per B6)
- ☐ Mobility: Stretcher (as per B6)
- ☐ Mobility: Seat near toilet
- ☐ Mobility: Airlift
- ☐ Ambulance for transfers
- ☐ Other :
- ☐ Escorting: Physician
- ☐ Escorting: Nurse / paramedic
- ☐ Escorting: Operational / "social"
- ☐ Escorting: Family
- ☐ Incontinence: Urinary catheter
- ☐ Incontinence: Diapers
- ☐ Oxygen – continuous Flowrate: l/min
- ☐ Oxygen – in reserve

End of mandatory section

Please complete next parts only when patients suffer from Mental disorder (C.I), and/or substance abuse (C.II), and/or epilepsy (D)

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PART C.I - Mental disorder, substance abuse or dependency

☐ **The patient has no mental condition or disorder, including substance abuse or dependency (you can skip this section)**

For persons suffering from substance abuse or dependency please also fill out questions C7 – C10)

C1. Is there current psychotic / abnormal behaviour?

☐ No ☐ Yes (please specify below)

C2. Is there a history of psychotic/abnormal behavior?

☐ No ☐ Yes (please specify below and provide date)

Date:

C3. Is there current aggressive behaviour to self or others?

☐ No ☐ Yes (please specify below)

C4. Is there a history of harmful behaviour to self or others?

☐ No ☐ Yes (please specify below and provide date)

Date:

C5. Has the patient ever refused medication?

☐ No ☐ Yes (please specify below, date and reason)

Date:
Reason:

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The UN Migration Agency

C6. To your knowledge, has the patient ever left from an institution/hospital without authorization?

☐ No ☐ Yes (please specify below date and reason)

Date:	
Reason:	

Part C.II - Substance abuse and / or dependency

☐ **The patient does not suffer from any substance abuse or dependency (you can skip this section)**

If the patient suffers from substance abuse / dependency please make sure Part C.I above is completed

C7. To your knowledge, when did the person start taking drugs? Date: ☐ Unknown

C8. Is the person currently under medically supervised substitution treatment?

☐ **Yes** (please specify below)

☐	Methadone	Since:	Dosage: mg/day
☐	Buprenorphine*	Since:	Dosage: mg/day
☐	Morphine*	Since:	Dosage: mg/day
☐	Naloxone*	Since:	Dosage: mg/day
☐	Other*	Since:	Dosage: mg/day

* *can the person switch to Methadone without risk?* ☐ Yes ☐ No

☐ **No**: but willing to begin substitution therapy
☐ **No**: and unwilling to begin substitution therapy
☐ **No**: substitution therapy prescribed but patient is non-compliant
☐ **No**: Other reason (please specify):

C9. To your knowledge, is the person taking other drugs while under substitution treatment?

☐ No ☐ Yes (please specify)

C10. Have you observed any withdrawal symptoms?

☐ No ☐ Yes (please specify)

End of Part C

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Part D - Epilepsy

☐ **The patient does not suffer from any epilepsy or seizure disorder (you can skip this section)**

D1. Is the epilepsy / seizure disorder well controlled?

☐ Yes (please specify medication):

☐ No (please provide remarks):

D2. Is the patient compliant with his / her medication?

☐ Yes ☐ No (please provide remarks):

D3. Please indicate the frequency and severity of seizures

☐ No seizures in the last 12 months

☐ Daily ☐ Weekly ☐ Twice a month ☐ Other:

Severity:

D4. Please provide information about the last known episode:

Date and duration of last episode:

Severity of last episode:

Injuries sustained ? ☐ No ☐ Yes (please specify):

D5. Please provide information about previous hospitalizations, if known

Date: Duration:

D6. Is there incontinence of urine and/or stool?

☐ No ☐ Yes, during the seizure ☐ Yes, all the time

End of Part D

End of Document