International Organization for Migration (IOM)
The UN Migration Agency

Request for a Medical Report and Assessment of Travel Fitness

Dear Doctor,

The International Organization for Migration (IOM) provides assistance to migrants who wish to voluntarily return to their countries of origin. In order to facilitate safe and dignified returns for the migrants and to ensure that the travel, frequently long and stressful, does not endanger the lives of migrants with significant medical conditions, IOM needs to establish that migrants are fit to travel, as well as make any special travel arrangements that might be necessary. To that end, IOM requests you to fill out the Annex A and/or to provide a complete medical report and answer specific questions related to travel in Annex B. Annex C and Annex D need to be filled out only for persons suffering from substance abuse or dependency and epilepsy.

Thanks for sending the filled-out form back to the return counselor in charge:

Mishelle Mettler & Sonja Zemmin
IOM Altstätten / Kreuzlingen / Zürich Flughafen
iomaltstaetten@iom.int / szemmin@iom.int
058 469 00 71 / 058 461 41 93

Please note that the airline might request another medical form to be filled out before the flight; IOM Bern will transfer the form to you if it is needed.

For further questions, we are always at your disposal.

Thank you very much for your cooperation!

Physician's name: Dr. med. Rüdiger Eisel

Physician's signature: _____

Date and place: 17.6.2019 Altstätten

Dr. med. R. Eisel
Innere Medizin & Nephrologie FMH
Rorschacherstr. 14a
9450 Altstätten
Tel. 071 757 87 67

IOM Bern
Thunstrasse 11
3000 Bern
www.ch.iom.int
031 350 82 11
More information on IOM Bern's project for voluntary return flights (available in German and French):
http://switzerland.iom.int/de/sim-de

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Patient's Consent for Disclosure of Medical Information

Patient's name *(printed or in block letters)*: Tabukaschvili, Margo
Patient's date of birth: 22.11.1950

I, Tabukashvili Margo (name of patient), hereby authorize
Dr. Ezel (name of physician) to disclose to IOM the medical information described in this request for the purposes of organizing my assisted voluntary return.

Date and place 17.6.19 Möhlin
Patient's signature: _____

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Annex A. Medical Report

a) Diagnosis

1) Dialysis dependent Chronic kidney disease
   - Hemodialysis 3 times / week
   - Etiology: diabetic nephropathy
2) Insulin dependent diabetes mellitus
3) Hypertension

b) Brief medical history (no need to list past diseases that have no relevance for travel, post-arrival re-integration or continuity of care)

longstanding Diabetes. Since October 2018 terminal chronic kidney disease with start of hemodialysis treatment, initially via ~~fem~~ catheter. AV-Fistula created in Georgia. In Switzerland we continued dialysis treatment 3 times / week for 4 hours each. Ultrafiltration 2-3 l / session. Medical treatment for hypertension continued. Insulin therapy for diabetes continued.

c) Vital signs:

To avoid additional requests for information, please provide vital signs, *at a minimum,* for patients with conditions that may be expected to affect vital signs (such as elderly returnees, those with advanced/terminal stages of diseases, cardiovascular, respiratory, renal, blood and other diseases, as per clinical judgement). **Oxygen saturation** should be provided, at a minimum, for patients with end-stage diseases, and cardiovascular, respiratory and blood disorders, including anemia. Please only provide vital signs that were actually measured; please mark vital signs that were not measured as "ND" (not done).

Temperature:	36,1°
Blood pressure (MmHg):	97/73 mmHg
Pulse rate per mn:	77/Min
Oxygen Saturation:	98%
Respiratory rate	14/Min

d) Major findings at physical examination

Weight 67kg, Height cm, lungs with normal sound, clear heart sounds, regular. No edema. Pulses normal. AV-fistula left arm Abdomen soft.

e) Relevant laboratory results

see list

f) Current treatment, including names of the drugs and dosages

see list

g) Recommendations for further follow-up and treatment, including timelines for follow-up (e.g. immediately, within X days/months)

Strictly need hemodialysis treatment 3 time/week.

Annex B. Fitness to Travel and Travel Arrangements

1. Is the patient able to make an informed and competent decision on return? Please include a psychiatrist's statement there are doubts about the migrant's capacity to take an informed decision.

   Yes ☒ No ☐

   Remarks, if any:

2. Is the patient considered fit to travel in his current condition?

   Yes ☒ No ☐

   Remarks, if any:

3. If the patient is fit to travel, does s/he need to be accompanied during the flight?
   Yes ☐ (→ please refer to question 7 for more details)
   No ☒

For questions 1, 2 and 3, please note that IOM physicians will base their decision on the treating physician's recommendation, as well as on IOM standards.

4. If the patient is not fit to travel, what needs to be done for the patient's stabilization to ensure that s/he can travel?

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

☐ Cannot sit upright for 30 min *(if the person cannot sit for takeoff and landing, a stretcher is needed; if the person can sit, but needs to lie down, a business class seat or 3 seats in economy class can be arranged)*
☐ Cannot walk within the plane *(special wheelchair in the cabin is needed)*
☐ Can walk within the plane, but has difficulties taking stairs *(wheelchair to the cabin is needed)*
☐ Mobile, but gets tired easily *(wheelchair to stairs is needed)*
☐ Other *(specify)*
☒ The patient does not have any of the above

Remarks, if any:

6. Does the patient require assistance with feeding, toilet or communication (e.g. the patient has hearing problems)?

Yes ☐ No ☒

If yes, please describe:

7. Recommended travel arrangements. *Please check all that apply*

☐ Urinary catheter ☐ Diapers
☐ Wheelchair to the stairs ☐ Wheelchair **up to** the cabin ☐ Wheelchair **in** the cabin
☐ Business class or 3 seats ☐ Stretcher ☐ Seat near toilet
☐ Oxygen. Flowrate: ___l/min ☐ Airlift
☐ Medical escort – Nurse/Paramedic ☐ Medical escort – Physician
☐ Operational escort[1] ☐ Family escort
☐ Ambulance in transit ☐ Ambulance upon arrival
☐ Other *(specify)*

Remarks, if any:

[1] An operational escort is a non-medical professional that provides mobility, communication and other logistical and social support to vulnerable migrants during travel.

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Annex C. Substance abuse or dependency

☐ Not Applicable (skip this section)

8. For all persons suffering from mental disorders, **substance abuse or dependency**, please answer the following questions:
    - Is there current psychotic/abnormal behaviour?

Yes ☐ No ☑

Remarks, if any:

- Is there a history of psychotic/abnormal behavior? If yes, please state the date of the last episode.

Yes ☐ No ☐ If yes, date:

Remarks, if any:

- Is there current aggressive behaviour to self or others?

Yes ☐ No ☑

Remarks, if any:

- Is there a history of harmful behaviour to self or others? If yes, please state the date of the last episode.

Yes ☐ No ☐ If yes, date: .....

Remarks, if any:

- Has the beneficiary ever refused medication? If yes, please state the reason and date.

Yes ☐ No ☐

Date:
Reason:

Remarks, if any:

- Has the beneficiary ever absconded from an institution/hospital? If yes, please state the reason and date.

Yes ☐ No ☐

Date:
Reason:

Annex D. Epilepsy

☑ Not Applicable (skip this section)

9. For all persons suffering from **epilepsy**, please answer the following questions:

- Is the epilepsy well controlled? Frequency of seizures?

Yes ☐ No ☐

Frequency of seizures *(e.g. daily, twice a month, no seizures in the last year)*:

- Is the patient compliant with his or her medication?

Yes ☐ No ☐

Remarks, if any:

- When was the last episode? How long did it last? Any injury during the attack?
- Previous hospitalizations? When and for how long?

Yes ☐ No ☐ If yes, date:

- Is there incontinence of urine and/or stool – all the time or during a seizure only?

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