Please fill in all boxes on the application form.
We need this information to provide you with our services, and although data may be shared for healthcare purposes, vital interests, legal reasons, or public interest, it will not be shared for marketing purposes without your explicit consent. For more detailed information on how we process your data and keep it secure, you can visit our website at www.qef.org.uk.uk/privacy/ or contact the office email or phone.

Tryb4uFly Application Form

Please complete using capital letters and return to the appropriate centre (page 3). Without the form we cannot book the appointment.

Reason for application – please tick left hand box		
	Tryb4uFly Cabin Transfer and Seating Assessment: A Health Professional will explain and demonstrate how you may be transferred into the airplane cabin, and you can 'Try' supportive seating systems in the air fuselage.	**£135**
	Tryb4uFly Consultation: A trained professional will go through the process of managing your travel booking and journey, from your front door through to the airplane and arrival at your destination.	**£135**

About the passenger	
First name:	Surname:
Date of birth: / /	Preferred pronoun/gender on passport
Address: Postcode:	
Email:	Phone number:
Weight:	**Height:**
Medical Diagnosis/es:	
What concerns do you have about flying?	

Who will be accompanying the passenger?	
First name:	Surname:
Email:	Phone number:
Address:	Relationship to the passenger:
Preparation for flying	
What specific medical advice have you been given regarding flying?	
Please detail the specific medical and mobility equipment you are considering travelling with:	
Flight information	
What advice have you been given by the airline assistance team?	

	Outbound	Return
Date of travel		
Airline		
Flight number		
Airport of departure		
Airport of stopover		
Airport of stopover		
Airport of arrival		

Declaration of consent
I understand that I/child/young person will be assessed and measured by the assessment team at QEF Mobility Services. **YES/NO**
I understand that the assessment may involve some manual handling to access any relevant equipment. **YES/NO**
I understand that the information on this referral form can be shared with other relevant agencies (dealer and equipment supplier) and professionals who need to know my child's circumstances. **YES/NO**
I understand I have the right to withdraw from the assessment at any time. **YES/NO**
I understand that there will be a 25% administration fee charge for all cancellations if another appointment is not required. **YES/NO**
I understand that if I fail to attend the appointment, or do not complete the assessment or if I do not give at least 7 days cancellation notice, the fee will not be refunded. **YES/NO**
I understand that staff may record images during assessments to provide additional content to the written report. **YES/NO**
I give consent for QEF Mobility Services to contact my doctor, if considered necessary, for any further medical information relevant to this assessment, which will be treated in strict confidence. **YES/NO**
Authorised signatory - please refer to your assessment centre of choice for cancellation terms and privacy notice
Signature of passenger/parent/guardian: PLEASE CIRCLE
Name in capitals:
Relationship to child/young person being referred:
Date:

List of centres	
QEF Mobility Services • Remote consultation • Cabin assessment 1 Metcalfe Ave, Carshalton SM5 4AW Tel: 0208 770 1151 Email: mobility@qef.org.uk	
William Merritt Centre • Cabin assessment Aire House, 100 Town St, Rodley, Leeds LS13 1HP Tel: 0113 350 8989 Text: 07858 224510 Email: info@wmdlc.org	

How did you find out about us?			
Internet		Doctor	
Friend/family		Therapist	
Social platform		Other health professional	
Other (please state)			

CLIENT NAME: .....DATE OF BIRTH ...../..... /.....

If you are over the age of 13 and wish for someone to act or speak on your behalf, please complete their contact details below.

Individual 1

Name: .....Relationship to client.....

Address.....
.....
Postcode:.....

Mobile.....Email.....

Please indicate when you would like QEF to contact the person named above: -

To make appointments on my behalf	YES □	NO □
To discuss progress, recommendations and outcomes	YES □	NO □
To make payments	YES □	NO □

Individual 2

Name: .....Relationship to client.....

Address.....
.....
Postcode:.....

Mobile.....Email.....

Please indicate when you would like QEF to contact the person named above: -

To make appointments on my behalf	YES □	NO □
To discuss progress, recommendations and outcomes	YES □	NO □
To make payments	YES □	NO □

Client signed ..... Name.....

Date .....

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EQUAL OPPORTUNITIES DATA

We are obliged to ask this information from the organisations that fund our service.

You do not have to answer these questions, and if you choose not to, this will not make any difference to the service you receive. This section of the application form will be detached, and the information collected will only be used for monitoring purposes in an anonymised format.

Ethnic Origin:

Asian Bangladeshi ( ) Asian Indian ( ) Asian Other ( ) Asian Pakistani ( )

Black African ( ) Black Caribbean ( ) Black Other ( ) Chinese ( )

Mixed Other ( ) Mixed White + Asian ( ) Mixed White + Black African

Mixed ( ) Mixed White + Black Caribbean ( )

White British ( ) White Irish ( ) White Other ( )

Ethnic Other ( ) Please specify_____

Declined to comment ( )