

**Mackenzie Holidays**  
**1-877-473-2726**  
**Fax: 1-585-624-5126**

**4 Livingston St.**  
**Honeoye Falls, NY 14472**  
**Email: info@mackenzieholidays.com**

## Medical Information from Your Physician

Patient, please sign here to give your physician permission to release your health information to Mackenzie Holidays and the medical crew on your cruise:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**Dear Physician:** Your patient has registered for a cruise for pulmonary patients. There will be 3-4 Respiratory Therapists and a nurse with the group. Please respond to the following questions about your patient so that we may prepare a cruise vacation with their comfort and safety in mind. Thank you in advance for your cooperation. If you have questions, please contact me at the above address. Pam Mackenzie, Owner, Mackenzie Holidays.

Patient's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Allergies: \_\_\_\_\_

Respiratory and Cardiac Diagnosis: \_\_\_\_\_

Summary of Present Condition: \_\_\_\_\_

Most Recent Cardiac/Pulmonary Exacerbation: \_\_\_\_\_

Other Health Problems: \_\_\_\_\_

Last Hospital Stay: \_\_\_\_\_ Reason: \_\_\_\_\_

Physical Limitations: Hearing: \_\_\_\_\_ Vision: \_\_\_\_\_ Ambulation: \_\_\_\_\_

Other: \_\_\_\_\_

Special Dietary Needs or Restrictions: \_\_\_\_\_

Last Pulmonary Function Tests: \_\_\_\_\_

Peak Expiratory Flow Rate: \_\_\_\_\_

Vital Capacity: \_\_\_\_\_ Forced Vital capacity: \_\_\_\_\_

Forced Respiratory Volume: \_\_\_\_\_

ABG's and/or Oxygen Saturation: \_\_\_\_\_ Date Obtained: \_\_\_\_\_

**Please Turn Sheet Over**

MEDICATIONS:

NAME	DOSAGE	ROUTE	FREQUENCY

Steroids Last Taken:Reason: \_\_\_\_\_

Antibiotics Last Taken:Reason: \_\_\_\_\_

Oxygen Therapy: \_\_\_\_\_

Patient Uses: Liquid \_\_\_\_\_ Gas \_\_\_\_\_ Concentrator \_\_\_\_\_

Liters Per Minute: \_\_\_\_\_ Hours Per Day: \_\_\_\_\_

Does Patient Need Supplemental Oxygen During Flight? \_\_\_\_\_

Liters Per Minute: \_\_\_\_\_

Other Treatments And Equipment Prescribed: \_\_\_\_\_

Physician's Name: (Print Please) \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date Of Patient's Last Exam: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Return to Mackenzie Holidays, 4 Livingston St., Honeoye Falls NY 14472  
or fax to: 585-624-5126**

ADDITIONAL NOTES: