ENFP MEDICAL EVALUATION

TO BE COMPLETED BY YOU

PATIENT CONTACT DETAILS:

NAME:	GENDER:
DATE OF BIRTH:	PHONE NUMBER:
ADDRESS:	
PASSPORT NUMBER:	NATIONALITY:

EMERGENCY CONTACT DETAILS

NAME:	RELATION:	PHONE:

TRAVEL INSURANCE:

INSURANCE PROVIDER:	
POLICY NUMBER:	24HR NUMBER:

At time of booking an appointment with your Medical Practitioner please specify to reception the purpose of your booking so that appropriate time may be allocated to completing the medical assessment. Please note that medical examinations for travel purposes may not attract a Medicare rebate.

I (Full Name) _____

consent for my Medical Practitioner to complete the following medical assessment which will be provided to the management staff of Experience Not Felt Possible and my Guide.

I consent to Experience Not Felt Possible contacting my Medical Practitioner to discuss any relevant details, and to my Medical Practitioner releasing any further relevant information to Experience Not Felt Possible and it's Insurers.

In a life threatening emergency or if a medical evacuation is required, I consent to Experience Not Felt Possible providing my medical information to my travel insurance company and/or treating medical staff.

I understand that this information will not be released to any other party (other than the above) without my prior consent.

_____

SIGNATURE

_____

DATE

TO BE COMPLETED BY EXAMINING MEDICAL PRACTITIONER

Dear Doctor,

_____intends to mountain bike / hike the upper Mustang region of Nepal.

The Upper Mustang experience is an 18 day tour that includes 12 days of actual activity. The experience is located in a remote part of Nepal. Participants will reach elevations up to 5,416m and over the entire tour, will ascend and descend over 13,000m in elevation.

This can be incredibly difficult and demanding. Your patient today has been advised of this and has been offered a training program designed specifically for this trek. We cannot guarantee that they have completed it but we do have minimum fitness benchmarks we expect our participants to meet 6-8 weeks prior to leaving. I ask that you advise us on their level of fitness and physical condition. Due to the exposure to altitude, long days and inconsistent trail surfaces, injuries are a major concern for your patient.

The trip is led by experienced Nepalese and Western guides. A first aider trained in wilderness first aid will be on the experience and will carry an extensive medical kit. That said, due to the remoteness, emergency medical services may not be readily available without Jeep or helicopter evacuation. We require all participants to carry an appropriate medical kit specific for emergency trauma and for their specific individual needs. There is limited access to medication once participants commence.

Participants will be required to have a high level of travel insurance as part of the experience. This will include full medical coverage, emergency evacuation and emergency repatriation.

The health of participants is our highest priority, and we require that each participant undergo and pass a fitness and medical assessment.

I appreciate your professional evaluation of your patient to ensure they are physically able to meet the challenge of this physically demanding activity.

- Please complete the following medical assessment.
- Please discuss and arrange with your patient any relevant pre-departure vaccination schedule and medications, including regular prescription medication and any recommended travel-specific medications. ENFP recommends considering the following:
  - Altitude related illness
  - Traveller's diarrhoea
  - Vaccine preventable disease (e.g. Tetanus, Hepatitis A, Typhoid)
  - Analgesia
  - Allergies (please note there are numerous bees on the track)
  - Dehydration & electrolyte disturbance

Thank you for your assistance in completing this medical assessment.

Please contact us if you require additional information pertaining to this request.

Kindest Regards,
Matthew Stewart
Director
Experience Not Felt Possible

Please review the following conditions/considerations and provide further relevant information as deemed appropriate. Please consider the impact such conditions may have on the participants health and advise on an appropriate management plan for the Experience.

CONDITION	RESPONSE		ADDITIONAL INFORMATION
Respiratory conditions	YES	NO	
Cardiac conditions	YES	NO	
Cardiac risk factors	YES	NO	
Renal conditions	YES	NO	
Diabetes	YES	NO	INSULIN DEPENDANT? YES/NO
Epilepsy	YES	NO	
Electrolyte Disorder	YES	NO	
Psychiatric Disorders	YES	NO	
Any recent operations	YES	NO	
Blood clotting disorder	YES	NO	
Phobias	YES	NO	
Allergies	YES	NO	EPIPEN REQUIRED? YES/NO
Other Conditions	YES	NO	

Weight:	Height:	BMI:
BP:	HR: REGULAR / IRREGULAR	RR:
BGL:	URINALYSIS:	

Do you consider your patient to be in good general health? **YES / NO**

If your patient has cardiac risk factors, do they require further risk stratification? **YES / NO / NA**

Do you recommend your patient undergo one or more of the following:

(Please circle)

ECG | Exercise Stress Test | Myocardial Perfusion Scan | Stress Echo | Other

In your opinion is your patient medically fit to participate in the experience? **YES / NO**

Additional comments:

_____

_____

_____

_____

_____

DOCTOR'S SIGNATURE

_____

DATE

DOCTOR'S STAMP

Please note that this document will be carried by our guides whilst on the tour. This document will be utilised as a quick access cumulative document in case of emergency. Participants should each carry their own copy and medication list.