CLIENT REFERRAL FORM

North East Patient Transport Service

Phone: 0403 989 847 **E-mail: ptnortheast@redcross.org.au**

Has the client travelled with Red Cross since June 2009 and provided information requested below?

NO ☐ (please complete page 2 and 3) **YES** ☐ (please only complete page 1)

If the client has previously provided details below, please update any information that may have changed.

Name of Referring Agency: ______________ Contact Person: ______________

Phone Number: ______________ Email Address: ______________

Client Details

Title: ______ Given Name: ______________ Family Name: ______________

Address: ______________

Suburb: ______________ Postcode: ______________

Date of Birth: ____ / ____ / ____

Phone Number: ______________ Mobile Number: ______________

Appointment Date: ______________ **Appointment Time:** ______________

Estimated length of appt.: ______________

Do you have an escort traveling with you? ☐ **Yes** ☐ **No**

Escort's Full Name: ______________ Relationship: ______________

Is the Escort a live-in carer? ☐ **Yes** ☐ **No** If Yes, complete page 3

Please indicate any medical conditions the service should be aware of:

____

Emergency Contact:

Name: ______________ Contact number: ______________

Please indicate any special needs or requirements of client (eg. Walkers, Wheelchair, Child restraint, Front seat etc):

____

Appointment Details

Hospital Name/Specialist Rooms Name: ______________

Address: ______________

Contact Person: ______________ Phone Number/Pager: ______________

Declaration:

I, ______________

(full name)

____

a

(Please state: registered Medical Practitioner/Health Professional/Transport coordinator)

request transport for the above mentioned person and declare that the person meets Red Cross's stated eligibility criteria* and has no other alternative transport arrangements.

Signature: Date :

(Signature of Medical Practitioner/Health Professional/Hospital Transport Coordinator)

Declaration:

***Clients eligible for transport are attending essential medical appointments, live in an area that is remote from public transport, are unable to drive or be driven to appointments, lives independently, do not qualify for a DVA card, TAC or Workcover, and are unable to engage an escort or carer to accompany them on public transport to appointments. Clients must be well enough to travel unassisted in a domestic passenger vehicle, in a seated position, and without medical personnel on board.**
Clients that require intervening treatment, intravenous therapy, oxygen or monitoring whilst in transit are ineligible for transportation.

Clients that require a wheelchair are only able to be transported if they are accompanied by a carer or family member that assumes responsibility for the loading and unloading of the wheelchair in and out of the vehicle.

Home and Community Care Client Details **Client Name:** ____________________

Information about the client:

Country of birth	Australia: ☐ **Yes** ☐ **No** Other, please specify:	
Preferred language:	English: ☐ **Yes** ☐ **No** Other: Interpreter? ☐ **Yes** ☐ **No**	
Sex	Please tick: ☐ **Male** ☐ **Female** ☐ **Intersex**	
Indigenous Status	**Does the client identify as a person of Aboriginal and/or Torres Strait Islander?**	**Please tick:**
	No	☐
	Yes, Aboriginal	☐
	Yes, Torres Strait Islander	☐
	Yes, of Aboriginal and Torres Strait Islander origin	☐

Please tick the statement that best describes the client in relation to the following questions.

Living arrangements	**Please tick:**
Lives alone	☐
Lives with family members	☐
Lives with people who are not family members	☐

Accommodation setting - the type of accommodation in which the client lives (one only)	**Please tick:**
a) **Private residence - owned/purchasing** (such as a house, flat, unit, caravan, mobile home, boat, marina)	☐
b) **Private residence - private rental** (such as a house, flat, unit, caravan, mobile home, boat, marina, etc. rented at market rates)	☐
c) **Private residence - public rental** (includes public housing authorities and community housing associations)	☐
d) **Independent living unit within a retirement village**	☐
e) **Boarding house/private hotel**	☐
f) **Short-term crisis, emergency or transitional accommodation facility** (includes night shelters, refuges and hostels for the homeless and temporary shelter within an Aboriginal community)	☐
g) **Supported accommodation or supported living facility** (includes Supported Residential Service (SRS) retirement villages and receiving care services)	☐
h) **Private residence rented from an Aboriginal community**	☐
i) **Institutional setting** (includes residential aged care facilities - hostels and nursing homes, and psychiatric/mental health community care facilities)	☐
j) **Alcohol and drug treatment residence**	☐
k) **Other, please specify**	☐

Government pension/benefit - does the client receive any of the following?	**Please tick:**

None	☐
Aged Pension	☐
Disability Support Pension	☐
Carer Payment (Pension)	☐
Unemployment related benefits	☐
Department of Veterans' Affairs (DVA) Pension	☐
DVA gold card	☐
DVA white card	☐
DVA other card	☐
Other Government pension or benefit, please specify:	☐

Home and Community Care Client Details **Client Name:** ____________________

Information about the live-in carer (if the client has a carer):

Does the carer live with the client?		☐ **Yes** ☐ **No**
Does the carer provide assistance on a regular basis to more than one person with a disability or chronic illness?		☐ **Yes** ☐ **No**
Please tick the statements which best describes the relationship of the carer to the client:		**Please tick:**
	Wife/female partner	☐
	Husband/male partner	☐
	Mother	☐
	Father	☐
	Daughter	☐
	Son	☐
	Daughter-in-law	☐
	Son-in-law	☐
	Other relative - female	☐
	Other relative - male	☐
	Friend/neighbour - female	☐
	Friend/neighbour - male	☐
Carer's given name:	**Carer's family name:**	
Date of birth	/ /	
Sex	Please tick: ☐ **Male** ☐ **Female** ☐ **Intersex**	
Suburb/town/locality		**Postcode:**
Country of birth	Australia: ☐ **Yes** ☐ **No** Other, please specify:	
Preferred language		
Indigenous Status	**Does the client identify as an Aboriginal and/or Torres Strait Islander?**	**Please tick:**
	No	☐
	Yes, Aboriginal	☐
	Yes, Torres Strait Islander	☐
	Yes, of Aboriginal and Torres Strait Islander origin	☐