Office Use:

Date Received/completed over phone Click or tap to enter a date.

Details Entered in TRIPS [ ]  Click or tap to enter a date.

Month entered in Mac Notes Spreadsheet Click or tap here to enter text.

**Group &/or Individual Transport Registration Form** Community Transport Services

**1. Personal Details: Private & Confidential** Please complete the following,and **CHECK** where appropriate

|  |  |
| --- | --- |
| **My Aged Care Number**  | Click or tap here to enter text. |
| **Do you have a Home Care Package (HCP)** | Yes [ ]  | No [ ]  |
| **If yes, name of Home Care Provider** | Click or tap here to enter text. |
| **Name of Case Manager supervising your HCP (if applicable)** | Click or tap here to enter text. |
| **If you are under 65 do you have an NDIS Package** | Yes [ ]  | No [ ]  | N/A [ ]  |

|  |  |
| --- | --- |
| **Title**  | Mrs [ ]  Ms [ ]  Miss [ ]  Mr [ ]  Other (please specify)Click or tap here to enter text.  |
| **Given Name** | Click or tap here to enter text. |
| **Surname** | Click or tap here to enter text. |
| **Preferred name if different to above** |   |
| **Date of Birth** |  Click or tap here to enter text. |
| **Gender**  | Female [ ]  | Male [ ]  | Other (Please specify)Click or tap here to enter text. |
| **Address *(Street Number and Name)*** |   |
| **Address *(Suburb and Postcode)*** | Click or tap here to enter text. |
| **Home Phone** | Click or tap here to enter text. |
| **Mobile Phone** | Click or tap here to enter text. |
| **Email** | Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Do you identify as Aboriginal or Torres Strait Islander -** Please check if applicable | Aboriginal [ ]  | Torres Strait Islander [ ]  | Both [ ]  |
| **Country of Birth**  | Australia [ ]  | Other (please specify) Click or tap here to enter text. |
| **Language/s spoken**  | English [ ]  | Other (please specify)Click or tap here to enter text. |
| **Do you require and Interpreter?** | Yes [ ] No [ ]  | If Yes, please confirm languageClick or tap here to enter text. |

**2. Your Primary Contact** (eg. case manager, next of kin, carer, guardian, POA, friend, emergency contact etc)

|  |  |
| --- | --- |
| **Surname of contact** | Click or tap here to enter text. |
| **First name of Contact** | Click or tap here to enter text. |
| **Relationship to you** | Click or tap here to enter text. |
| **Street Address of contact** | Click or tap here to enter text. |
| **Suburb of contact** | Click or tap here to enter text. | **Postcode**Click or tap here to enter text. |
| **Phone numbers of contact** | Click or tap here to enter text. | MobileClick or tap here to enter text. |
| **Email of contact** | Click or tap here to enter text. |

**3. Your Circumstances**

|  |  |  |  |
| --- | --- | --- | --- |
| **Accommodation Setting for Transport accessibility** | House [ ]  | Terrace [ ]  | Block of units [ ]  |
| Retirement Village [ ]  | Supported Residential Services[ ]  | Other (Please specify)Click or tap here to enter text.  |
| **Are there any risks or barriers on or near your property that the volunteer driver should be aware of** (eg. dogs, locked gates, intercoms) | Yes [ ]  | No [ ]  | (Please specify)Click or tap here to enter text. |

**4**

**4. Your Wellbeing, Safety and Risk**

We are mindful that the utmost safety is essential when delivering transport services and we aim to minimise risk for all.

|  |  |  |  |
| --- | --- | --- | --- |
| **Sensory Information** | Vision/ hearing impairment (please specify)[ ] Click or tap here to enter text. | Speech – loss or impairment (please specify)[ ] Click or tap here to enter text. | Physical/diverse – physical disability, acquired brain or neurological injury (eg. seizures - please specify))[ ] Click or tap here to enter text.Do you have memory issues, confusion (e.g. dementia, forgetfulness) [ ]   |
| Intellectual/Learning/behavioural [ ] Click or tap here to enter text. | Psychiatric[ ] Click or tap here to enter text. |
| **Do you have cultural, linguistic or any specific needs you wish us to be aware of**  | (If **yes** please specify)Click or tap here to enter text. |

**6. Mobility**

|  |  |  |
| --- | --- | --- |
| **Do you use a mobility aid?** | Walking Stick [ ]  | Walking Frame [ ]  |
| **Please note our cars cannot accommodate Wheelchair Users/minibuses can be used if available** | Manual wheelchair [ ]  | Electric wheelchair [ ]  |
| **Wheelchair Users: can you transfer independently into a vehicle seat** | Yes [ ]  | No [ ]  |
| **Do you require assistance** | Crossing the road [ ]  | Getting in and out of a vehicle [ ]  | Other (please specify)Click or tap here to enter text. |
| **Do you comfortably fit into a standard vehicle seat** | Yes [ ]  | No [ ]  |
| **Are you able to manage 2 steps up and down on a minibus** | Yes [ ]  | No [ ]  |
| **Can you walk from your home to a parked vehicle (approx. 100 metres) with or without a mobility aid** | Yes [ ]  | No [ ]  |

**çççç**

**7. Travelling with a Carer**

|  |  |  |  |
| --- | --- | --- | --- |
| **Do you have a carer/other person who would travel with you to appointments?** | Yes [ ]   | No [ ]  | Sometimes [ ]  |
| **If YES or SOMETIMES, please provide details*****This person will also need to register with our service*** | Name Click or tap here to enter text. | Relationship to youClick or tap here to enter text. |

**8. Transport Requests**

|  |  |  |
| --- | --- | --- |
| **Please select the transport service/s you require. (**See below) | Individual Transport [ ] ie: external appointments to such things as medical/hospital, shopping assistance, physio | Group Transport for approved Connect Health programs [ ] ie: internal Connect Health & Community activities/programs eg. tai chi, falls mobility, hydro, allied health |
| **If Group Transport please indicate (**x**) what program the transport is required for**  | 1. Tai Chi [ ]
2. Social Support Group: Mon [ ]  Tues [ ]  Thurs [ ]
 |

|  |
| --- |
| **Who will be making your transport requests (this will be the primary contact for Community Transport)** An alert will be put on your file to make all contact through this person. **Leave blank if the client is the primary contact for all Community Transport communication.** |
| **Nominated Representative’s name** | Click or tap here to enter text. |
| **Relationship to the Service User** | Click or tap here to enter text. |
| **Nominated Representative’s Signature** | Click or tap here to enter text. |
| **Nominated Representative’s Contact Phone Number** | Click or tap here to enter text. | **Date**Click or tap to enter a date. |

 **9. Permission for Connect Health & Community (CH&C) to Contact You**

|  |  |  |
| --- | --- | --- |
| I give permission for CH&C to call, SMS or email me about my current serviceor other services they have that may be of interest to me | Yes [ ]  | No [ ]  |

 **10. Payment/Invoicing (Bi-Monthly)** For all enquiries please ring Finance on 9575 5360 (Mon - Thu 8:30AM - 3:00PM)

 Person responsible for payment of the service. **If NOT you** please complete their details below

|  |  |
| --- | --- |
| **Name** | Click or tap here to enter text. |
| **Address** | Click or tap here to enter text. |
| **Phone** | LandlineClick or tap here to enter text. | MobileClick or tap here to enter text. |
| **Email** | Click or tap here to enter text. |

**Transport Service User Consent**

Connect Health needs to collect information about you to make a thorough assessment and for the purpose of providing a quality service to you. We manage your personal information in accordance with relevant laws.

Connect Health:

* Holds personal information about me
* Securely stores either; electronically and/or in hard copy file of my personal information, which may include databases provided by funding bodies.
* Collects and reports statistical information to funding bodies in a way that does not identify me.
* Will provide information about my rights and responsibilities including privacy and confidentiality, access to information and the complaints/feedback process.
* Uses various technologies to monitor the safety of staff including the location of Connect Health vehicles, CCTV, onsite and remote duress alarm monitoring.
* Understands that I have the right to change my mind and withdraw informed consent at any time. Consent is valid for the period I am engaged with the service.

I understand and give my consent.

 Yes [ ]  No [ ]

For the purpose of providing a quality service, I agree to my information being:

*Please check all*

[ ]  Shared with other Connect Health programs to provide me the best possible service.

[ ]  Used in measurement tools to assist with goal planning and monitoring outcomes.

[ ]  Audited to ensure Connect Health meets quality standards and funding requirements.