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 language  Click 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 service  or 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.