Western Health Specialist Clinics
Non Emergency Patient Transport Request Form

Non Emerg Transport is available to Aged-Disability-Widow and HCC Pensioners for MEDICAL reasons only
Forms to be completed in full and faxed with a minimum notice of 5 WORKING DAYS prior to appt date

Patient Transport Coordinator **Mon to Fri 8.00 to 4.30**	Tel: 834 51157 Fax: 834 50157 (no bookings processed W/ends P/H)

Patient Details:

Western Health Patient ID Number : _____ DOB_____ GENDER: _____

Surname: _____ Given Name:_____

Pick-Up Location:

Care Facility Name (if applicable):_____

Address: _____ _____

Tel:_____ Fax:_____

Appointment Details:	**Appointment Location:**
Date: _____ Appointment Time:_____ Pick Up Time:_____ **(Pick up time to be 1 HR Prior to appointment)** **RETURN TRIP REQUIRED?** ☐ YES ☐ NO	Hospital Site:: _____ Clinic Name: _____

Escort: Mandatory for ALL transport requests –(Confirm one of the below prior to sending your booking)

Carer/Family ***travelling with patient***? (subject to vehicle capacity) ☐ Carer/Family ***meeting at appointment***? ☐

List of Current Medical Conditions/History (mandatory)-

Infectious Disease: ☐ Yes ☐No Specify: VRE/MRSA/Other……	Is the patient? ☐ Visually impaired ☐ Hearing impaired Specific Requirements: ☐ Catheter ☐ Suction ☐ IV ☐ Monitor

Transport Type/Mode Required-(Tick)

☐ Walker *(able to climb 2 steps & enter/exit sedan vehicle)*	☐ Wheelchair *(patient to provide)* ☐ Man? ☐ Elec? ☐Transfer with assistance ☐ Confined
☐ Walker Assist -requires wheelchair for ability/distance?	☐ Stretcher ***(only if severe mobility issues/bed bound)***
Equipment / Mobility Aids	**Patient Weight: Please tick and add in weight/girth**
☐ Wheelchair ☐ Walking Frame ☐ Walking Stick ☐ Oxygen requirements- ☐ On Portable ☐ Concentrator 02 (requires stretcher)	☐ < 100 kg ☐ 100 – 130 kg ☐ 131-230 kg ☐ 230 kg >/+ **ACTUAL WEIGHT_____ (if 100kg's +)** **ACTUAL GIRTH_____(if 100kg's +)**

Patient Category (Tick)

☐ Pensioner ☐ Health Care Card ☐ TAC ☐ Work Cover ☐ DVA white/gold ☐ Ambulance Member
Card/Ref No _____

Authorizing Doctor/DIV 1

PRINT NAME:_____ Position GP/DIV 1- _____

Signature:_____ Date:_____

Western Health CONFIRMATION BOOKING NUMBER: ……