WESTERN HEALTH - TRANSPORT REQUEST FORM

Specialist clinic and Pre Admission Clinic appointments only

Western Health

Note-All other attendances are serviced by Ambulance Victoria

* = Mandatory. Form will not be processed if form is incomplete.

Non Emerg Transport is available to Aged-Disability-Widow and HCC Pensioners for MEDICAL reasons only

Booking requests are to be submitted with a minimum notice of **5 WORKING DAYS prior to appointment date**

Patient Transport Coordinator Inquiries- 8345 1157 Mon to Fri - 8.00 to 4.00

Patient Details*:

Western Health Patient ID Number : _____ **DOB** **GENDER: M** ☐ **F** ☐

Surname: _____ **Given Name**:_____

Pick-Up Location*:

Care Facility Name (if applicable):_____

Email address:_____

Street Address: _____ **Suburb**: _____ **Postcode**: _____

Phone: _____ **Contact Name**: _____

Appointment Details*:

Date: **Return Journey**: Yes ☐ No ☐ _____ **Appointment Time**: __:__ **Pick Up Time:**__:__

(Pick up time to be 1 HR prior to appointment)

Appointment Location*:	**Clinic Name:**
Hospital Site: Sunshine ☐ Footscray ☐ Williamstown ☐ Sunbury ☐	_____

ESCORT: Mandatory for ALL transport requests – Carer is to be confirmed prior to booking

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

List here- Current Medical Conditions/History-

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)* ☐ Manual? ☐ Electric? ☐Transfer with assistance ☐ Confined
☐ Walker Assist -requires wheelchair for ability/distance?	☐ Stretcher ***(only if severe mobility issues/bed bound)***
Equipment / Mobility Aids*	**Patient Weight/Height/Girth***
☐ Nil ☐ Wheelchair ☐ Walking Frame ☐ Walking Stick ☐ Oxygen requirements- ☐ On Portable ☐ Concentrator 02 (requires stretcher)	☐ **< 100 kg** ☐ **100 – 130 kg** ☐ **131-230 kg** ☐ **230 kg >/+** **100 kgs WEIGHT** _____ **Height cms** _____ **GIRTH .05-.07 >** ☐ **Exceeds .07 >** ☐

Patient Category (Tick)*

☐ Pensioner ☐ Health Care Card ☐ TAC ☐ Work Cover ☐ DVA white/gold ☐ Ambulance Member

Card/Ref No _____

Authorizing Doctor or DIV 1*

Position GP/DIV 1- _____

NAME:

Date: _____

A confirmation number will be replied to the online booking request

Click on button to SEND