TRANSPORT REGISTRATION FORM - CONFIDENTIAL

If you are over the age of 65 years, please contact myagedcare on 1800 200 422 to register for Community Transport

PART A Please complete information and circle correct answer where appropriate.

Given Name:	Preferred Name:	Family Name:
Date of Birth**:** / /	Male / Female / Other	Indigenous or Torres Strait Islander YES / NO
Contact number:	Mobile:	
Country of Birth:	Main language spoken at home:	Do you have cultural or linguistic needs? YES / NO If yes please state:
Address(for transport pick-ups)		
Postal Address: (if different from above)		
Email:		

PART B – Emergency Information

Emergency Contact Name:	Telephone:	Relationship to you
Doctors Name:	Contact number:	Medicare Number:

PART C – Type of Income:

Do you receive an Aged Pension YES / NO Full Pension / Part Pension / Other *(please state)* (please circle and write number)
Are you receiving a DVA Pension : Gold / White Card / orange / other *(please state)* *DVA number*
Are you on a Homecare Package: YES / NO if Yes contact details for provider
Are you on an NDIS package: YES / NO if Yes contact details for provider **NDIS number:**
Are you receiving any benefits from Centrelink *if yes please state and write number)*

Please turn over

PART D- Accommodation

Are you a home owner YES / NO	**Do you rent** Private rental / Public Housing / Other *(please state)*	**Do you live alone?:** YES / NO	**Whom do you live with?**
Do you have a carer who will need to travel with you? YES / NO if yes please write details below			

Please note, if you do have a carer, they will also have to register for transport to travel with you.

PART E – Your abilities for transport requirements

The following Information will be used to assess the level of assistance you might require when travelling with Community Transport.

Do you use a Walking Frame YES / NO	**Do you use a Walking stick** YES / NO
Do you have a wheelchair YES / NO if yes, please state type of chair. Eg; Electric / Bariatric / Push Chair	**Do you use Oxygen**? If yes please circle Tank /Cylinder or Concentrator
Do you have any health issues that will affect service delivery? ☐Visual impairment ☐Poor Balance ☐Memory loss ☐Incontinence ☐Obesity ☐Breathing Difficulties ☐ Other (please state)……	

Can you move independently? From home to vehicle	YES / NO
Can you manage 2 to 3 steps independently?	YES / NO
Can you manage alone at your destination?	YES / NO
Are there any issues for a vehicle to your home? Eg: no driveway, narrow driveway	YES / NO

CONSENT STATEMENT

I, _____understand that the information I have provided is correct.
I understand MVACTG will retain my personal information on file for the purpose of providing me with a safe service. And that MVACTG are required to report, non-identifying information to funding bodies for funding, planning and statistical purposes.
I understand that from time to time photos or videos may be taken during the course of our activities and used for promotional purposes.

Signature Client: _____Date: _____

Office use only: ***Handbook sent to client YES / NO sent by:_____ Date sent_____***

MAC client: YES / NO if yes, Aged Care User ID_____ _____ MAC Priority L / M / H

Date referred by MAC: _____ Date Accepted: _____ Funding Source_____

MAC office Allocation F / G / T / TG Date form returned: _____

Routmatch ID _____Date entered into Routematch : _____ ***Entered by***_____

Notes:_____

_____