HEALTH & COMMUNITY TRANSPORT REQUEST FORM

Customer Reference No. ....

Transport Service: *(delete as appropriate)*	**ALD**	**PSD**	**MH**	**OP**	**ILS**	**ICS**
	Adults with Learning Disabilities	Physical & Sensory Disabilities	Mental Health	Older People	Independent Living Services	Intermediate Care Services

Service User's Name: .... **Date of Birth:** ....

Address: ....

....

Post Code: .... **Telephone Number:** ....

Carer/Next of Kin Name: ....

Relationship: .... **Telephone Number:** ....

Alternative Emergency Address: ....

Social Worker Name: .... **Contact Number:** ....

Transport Details: Regular / One Off / Short Term / Temp Medical / Alteration / Recommence / Additional

Cancellation: Permanent / Until Further Notice / One Off

Day(s): .... **Date effective:** .... **Times:** ....

From: ....

To: ....

Can Travel: On Fleet Vehicle **Y / N** In taxi **Y / N** In Minibus **Y / N**

With Volunteer Driver **Y / N** With Other Service Users **Y / N**

On Bus Service with a Travel Pass **Y / N** Travel Training Required **Y / N**

....

Transport Choice Preference 1: **Transport Choice Preference 2:**

....

Eligibility Criteria Met: **YES / NO** **Service User / Carer Agreed to Charges** **YES / NO**

.... **(Please Strike Through)** **Signed By:** ....

If not statutory distance, state reason transport awarded: ....

Risk Assessment Date: ....

Special Conditions: ....

Nature of disability: ....

Passenger Assistant Required: **YES / NO** **Any Specific Requirement:** ....

Medication Details: .... **Access Requirements:** ....

Can be left at home alone: **YES / NO** **Any Other Information:** ....

Mobility: .... **Mobility Aids:** ....

IF WHEELCHAIR, PLEASE COMPLETE CONTINUATION SHEET

Requested by (Name): .... **Contact No:** ....

Authorised by (Name): .... **Team:** ....

Position: .... **Contact No:** ....

Above Request Meets Criteria: **Y / N** **If No, Reason:** ....

If No, has been agreed by Divisional Manager: **Y / N** **Name of DM:** ....

CONTINUATION SHEET

Service User's Name: --

Wheelchair Type: Manual / Powered Model: --

Wheelchair Dimensions: Height: ---------------- Length: ------------------- Width: ---------------------

If can transfer, can wheelchair be folded: YES ☐ NO ☐ N/A ☐

2nd Wheelchair Type: Manual / Powered Model: --
(If Applicable)

Wheelchair Dimensions: Height: ---------------- Length: ------------------- Width: ---------------------

If can transfer, can wheelchair be folded: YES ☐ NO ☐ N/A ☐

Seating System: YES ☐ NO ☐ Details: --

Wheelchair Weight: ---------------------------------- Passenger's Weight: --------------------------------------

Overall Weight (wheelchair with occupant): --

MODIFICATIONS FOR MAIN WHEELCHAIR (please provide details):

Knee Blocks:	YES	☐	NO	☐	Details: -----------------------------------
Elevating Leg Rest:	YES	☐	NO	☐	Details: -----------------------------------
Footboard:	YES	☐	NO	☐	Details: -----------------------------------
Tray:	YES	☐	NO	☐	Details: -----------------------------------
Communication Aid Mounting:	YES	☐	NO	☐	Details: -----------------------------------
Oxygen Cylinder Carrier:	YES	☐	NO	☐	Details: -----------------------------------
Recliner Back:	YES	☐	NO	☐	Details: -----------------------------------
Extended Back Rest:	YES	☐	NO	☐	Details: -----------------------------------
Head Rest:	YES	☐	NO	☐	Details: -----------------------------------
Kerb Climbers:	YES	☐	NO	☐	Details: -----------------------------------

Harness Type: --

RETURN BY: e-mail: transport.co-ordination@halton.gov.uk fax: 0151 471 7521