

CLIENT RECORD FORM

Please complete information and circle correct answer where appropriate.



PART A

CONFIDENTIAL

Mr/Mrs/Miss/Ms/Dr	Given Name:	Family Name:		
Date of Birth: / /	Age:	Male/Female		
Usual Address:				
				Postcode:
Telephone:	Mobile:	Email:		
Current Address (if different):				
				Postcode:

PART B

Emergency Contact:	Telephone:	Relationship:
Doctor's (GP) Name:	Doctor's Telephone:	
Are you Aboriginal or Torres Strait Islander? Yes/No	Country of Birth:	
Main Language:	Do you have a carer? Yes/No If Yes, complete PART F	
Do you live alone? Yes/No If No, who do you live with? ie. relative, friend		

PART C

Income: Pension - Aged / DVA / Disability OR Other.....	If DVA Pension: Gold Card / White Card / Other
Living Arrangements: Home: Owned / Private Rental / Public Rental / Other.....	
Relevant Health Issues/Difficulties:	

PART D - What is your ability to:

Do HOUSEWORK?	Without Help / With Help / Completely Unable
Get places further than walking distance? (TRANSPORT)	Without Help / With Help / Need specialised vehicle or ambulance
Go out for SHOPPING for groceries and clothes?	Without Help / With Help / Completely Unable
Take your own MEDICATION?	Without Help / With Help / Completely Unable
Handle own MONEY?	Without Help / With Help / Completely Unable
To WALK? ie. walking stick, frame, wheelchair	Without Help / With Help / Completely Unable
To BATHE/SHOWER?	Without Help / With Help / Completely Unable
DRESS yourself?	Without Help / With Help / Completely Unable
EAT?	Without Help / With Help / Completely Unable
Go to the TOILET by yourself?	Without Help / With Help / Completely Unable
To get out of BED and MOVE around?	Without Help/With Help Sometimes/With Help Always

PTO - Please complete PART E & F & sign PART G

PART E

Do you need help to communicate? No / Sometimes / Always	Do you need an interpreter? Yes/No
If access to your home is difficult, explain briefly:	
Do you use: Walking Stick / Walking Frame / Wheelchair	Do you suffer from: Visual Impairment / Balance / Memory Loss
Do you receive other services from Home & Community Care? ie. Meals on Wheels, Gardening, Cleaning Yes/No	
How did you find out about Community Transport?	
I require transport for: Medical / Social / Shopping	

PART F - CARER DETAILS- only complete if a carer/friend will travel with you.

Carer Given Name:		Carer Family Name:	
Date of Birth: / /		Male/Female	
Carer address:			
State:		P/Code:	Phone:
Carer Country of Birth:		Main Language:	
Is Carer Aboriginal or Torres Trait Islander? Yes/No			
Does Carer care for more than one? Yes/No			
Carer Residency Status: Co-resident Carer / Non-resident Carer			
Client/Carer Relationship: Friend or neighbour / Other relative / Parent /Son or Daughter			

PART G – THIS SECTION MUST BE COMPLETED - CONFIDENTIAL

I consent/do not consent to this information, being used for reporting statistics to our funding bodies. All personal information is encoded and completely confidential.

Signature..... Date.....

I give/do not give permission for my image (photo) to be used in displays, newspapers or reports promoting our service.

Signature..... Date.....

Please complete and return to: Ryde Hunters Hill Community Transport PO Box 162, Gladesville, 1675	Telephone: 9816 5000 Fax: 9816 5044
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OFFICE USE ONLY: <input type="checkbox"/> EK <input type="checkbox"/> PIB <input type="checkbox"/> TMA <input type="checkbox"/> TRIPS <input type="checkbox"/> SP <input type="checkbox"/> Member <input type="checkbox"/> Welcome Let Date Received:
