

NOARLUNGA VOLUNTEER TRANSPORT SERVICE INC.

ADMINISTRATION/REFERRAL FORM

Client Personal Details							
Title		Surname		Given Name			
Preferred Name				Marital Status			
Telephone					Email:		
<i>Property title, if applicable e.g. retirement village</i>							
Address						Post code	
Gender	Male	Female	Date of Birth	/ /	Age		
Aboriginal or ATSI	Yes	No	Has a carer		Yes	No	
Country of Birth			Lives with carer		Yes	No	
Language spoken at home:			Has non-resident carer		Yes	No	
Interpreter required	Yes	No	Carer relationship to client				
			The client is a carer		Yes	No	

Support/Emergency Contact Person							
Title		Surname		Given Name	Preferred Name		
<i>Property title, if applicable e.g. retirement village</i>							
Address						Post code	
Telephone					Email:		
Gender	Male	Female	Relationship to client				

Income			
Does the client get a pension?	Yes	No	If Yes, pension number is:
Type of Pension	Aged	Full Part	DVA Gold White Other
MEDICARE NO.			



Equipment used to maintain independence		
Walker	Yes	No
Walking Stick	Yes	No

Relevant Health Information
What does the client see as difficulties and/or health problems (e.g. hearing, allergies, eye sight)
How will any of these affect service delivery?

Medical Practitioner		
Name		Telephone number
Surgery name & address		

My Aged Care		
Can the client be assessed over the phone?	Yes	No
I consent to My Aged Care contacting me.	Yes	No

Home and Safety Access

Are there any factors about this home that could affect Safety/for access (eg. Dog) by:

Service providers Yes No

If yes, what are they?

Client Signature

Comment if the client is unable to sign
(e.g verbal agreement)

Date / /

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