



CLIENT REGISTRATION/ASSESSMENT FORM - CONFIDENTIAL

PART A

Please complete information and circle correct answer where appropriate.

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:	Medicare No:
Are you Aboriginal or Torres Strait Islander? YES/NO	Country of Birth:	
Main Language:	Do you have cultural or linguistic needs? YES/NO If yes, please state:	
Do you live alone? YES/NO Whom do you live with?	Do you have a carer? YES/NO If Yes, complete PART F	

PART C

Income: Type of Pension: Aged / DVA / Disability/Other If DVA Pension: Gold Card / White Card / Other	Full Pension/Part Pension (please circle and write number below) Pension No:
Living Arrangements: Home: Owned / Private Rental / Public Rental / Other.....	

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
Do you need help to communicate?	No / Sometimes / Always

PTO - Please complete PART E & F(if applicable) & sign PART G

PART E (please tick boxes)

(please circle)

Do you have any health issues that will affect service delivery? Please state:	YES/NO
<input type="checkbox"/> Visual Impairment <input type="checkbox"/> Poor-Balance <input type="checkbox"/> Memory-Loss <input type="checkbox"/> Incontinence <input type="checkbox"/> Obesity <input type="checkbox"/> Other	
How much do you weigh? <input type="checkbox"/> Under 100kg <input type="checkbox"/> 100-130kg <input type="checkbox"/> 130-150kg <input type="checkbox"/> Over 150kg Do you require <input type="checkbox"/> Bariatric seat <input type="checkbox"/> Extension seatbelt	Please tick boxes
Do you use: <input type="checkbox"/> Walking Stick <input type="checkbox"/> Walking Frame Is Walking Frame collapsible? Can you navigate 2 (low) steps in/out of our bus?	YES/NO YES/NO/UNSURE
Do you use Wheelchair: If yes, <input type="checkbox"/> Manual <input type="checkbox"/> Electric Is Wheelchair collapsible? Wheelchair Weight: <input type="checkbox"/> <100kgs <input type="checkbox"/> >100kgs Can you transfer independently to vehicle?	YES/NO YES/NO/UNSURE
If you answered "Unsure" for any of the above, would you like an on-site assessment?	YES/NO
ACCESS TO HOME: Is it safe for our vehicle to stop outside your home? Please state ALL access difficulties:	Car YES/NO Bus YES/NO
Do you need front seat of car?	YES/NO
Do you need back seat of car?	YES/NO
Can you travel in a taxi?	YES/NO
Do you have <input type="checkbox"/> Guide Dog <input type="checkbox"/> Oxygen Cylinder <input type="checkbox"/> Other:	N/A
How did you find out about us? <input type="checkbox"/> Website <input type="checkbox"/> Newspaper <input type="checkbox"/> Friend/Family <input type="checkbox"/> Health Professional <input type="checkbox"/> Letterbox drop <input type="checkbox"/> Other	
I require transport for: Medical / Social / Shopping / Access to:	

PART F - CARER DETAILS

Carer's Given Name:		Carer's Family Name:	
Carer's Date of Birth: / /		Male/Female	
Carer's 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			
Will Carer be travelling with you?			YES/NO/SOMETIMES

PART G – Please sign

I understand that by using this service I consent to Ryde Hunters Hill Community Transport reporting non-identifying information to funding bodies (if applicable) for planning and statistical purposes. I understand that I will be notified in writing of the success or otherwise of my assessment and that I will receive an information welcome letter and a copy of the Passenger Handbook outlining my rights and responsibilities. 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..... **Date**.....

I am on an NDIS package, and self-managing my package OR

I am on an NDIS package and the NDIA is managing my package. My NDIA number is:.....

I am not eligible for an NDIS package.

To discover if you are eligible for an NDIS package call 1800 800 110 or go to www.myplace.ndis.gov.au

*NDIS = National Disability Insurance Scheme

Please complete and return to: Ryde Hunters Hill Community Transport Assoc. Inc PO Box 162, Gladesville, 1675	Telephone: 02 9816 5000 Fax: 02 9816 5044 Email: info@rhct.org.au
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Forms can be downloaded from www.rhct.org.au

OFFICE USE ONLY: HB sent TMA TRIPS SP Member Welcome Let

Date/Initial: _____