



# HEALTH & COMMUNITY TRANSPORT REQUEST FORM

Customer  
Reference No.

.....

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

<b>Service User's Name:</b> .....	<b>Date of Birth:</b> .....
<b>Address:</b> .....	
.....	
<b>Post Code:</b> .....	<b>Telephone Number:</b> .....
<b>Carer/Next of Kin Name:</b> .....	
<b>Relationship:</b> .....	<b>Telephone Number:</b> .....
<b>Alternative Emergency Address:</b> .....	
<b>Social Worker Name:</b> .....	<b>Contact Number:</b> .....

<b>Transport Details:</b>	Regular / One Off / Short Term / Temp Medical / Alteration / Reconnence / Additional		
<b>Cancellation:</b>	Permanent / Until Further Notice / One Off		
<b>Day(s):</b> .....	<b>Date effective:</b> .....	<b>Times:</b> .....	
<b>From:</b> .....	.....		
<b>To:</b> .....	.....		
<b>Can Travel:</b>	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	
<b>Transport Choice Preference 1:</b> .....		<b>Transport Choice Preference 2:</b> .....	
<b>Eligibility Criteria Met:</b>	YES / NO	<b>Service User / Carer Agreed to Charges</b>	YES / NO
		<b>(Please Strike Through) Signed By:</b>	
<b>If not statutory distance, state reason transport awarded:</b> .....			

<b>Risk Assessment Date:</b> .....	.....		
<b>Special Conditions:</b> .....	.....		
<b>Nature of disability:</b> .....	.....		
<b>Passenger Assistant Required:</b>	YES / NO	<b>Any Specific Requirement:</b>	.....
<b>Medication Details:</b> .....	<b>Access Requirements:</b> .....		
<b>Can be left at home alone:</b>	YES / NO	<b>Any Other Information:</b> .....	
<b>Mobility:</b> .....	<b>Mobility Aids:</b> .....		

IF WHEELCHAIR, PLEASE COMPLETE CONTINUATION SHEET

<b>Requested by (Name):</b> .....	<b>Contact No:</b> .....
<b>Authorised by (Name):</b> .....	<b>Team:</b> .....
<b>Position:</b> .....	<b>Contact No:</b> .....
<b>Above Request Meets Criteria:</b>	Y / N
<b>If No, Reason:</b> .....	
<b>If No, has been agreed by Divisional Manager:</b>	Y / N
<b>Name of DM:</b> .....	



# 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

2<sup>nd</sup> 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](mailto:transport.co-ordination@halton.gov.uk) fax: [0151 471 7521](tel:01514717521)