

# ST PETER'S DAY HOSPICE

## TRANSPORT/ MOBILITY AND HANDLING REQUEST FORM

<b>PATIENT DETAILS</b>	<b>JOURNEY DETAILS</b>
Surname: First Name D.O.B. Address:	Date and time of Journey:  Journey From:  Journey to:

<b>ACCESS DETAILS</b>
Type of property?
Driveway?
Are there parking problems?
If YES please state:-
Which door is most suitable to use?
Does patient have far to walk to the car?
Number of steps to the door?
Is there a ramp?
Is it wheelchair accessible?
<b>PERSONAL DETAILS</b>
Does patient have any communication/ concentration problems? Yes/ No
If yes please state problem:-

<b>PATIENT'S MOBILITY</b>	
1. Can patient walk unaided? If NO, please describe aids used:	YES/NO
2. Can patient get in and out of car unassisted? If NO, please state assistance required:	YES/NO
4. Would patient prefer to sit in front/back of car?	YES/NO
6. Can patient wear seat belt? If NO, patient will not be able to have hospice transport.	YES/NO

<b>OXYGEN REQUIREMENTS</b>	
Does this patient require oxygen?	YES/NO
Will this patient be traveling with a portable oxygen supply?	YES/NO

Any other relevant information the driver might require:

Signature of person completing form.....

Name ..... Position.....Date.....