

If this is an Emergency or there is a clinical requirement for transport within 90 minutes, call 000 now

Metropolitan

(Metro Transfers Only)

Walker, Walker Assist and Wheelchair | Phone: 1300 360 929 (enquiries/cancellations) | Email: cts.bookings@ambulance.vic.gov.au

Fax: 1300 361 929 (bookings)

CLINIC TRANSPORT SERVICES BOOKING FORM

Patient's Given Name:

Patient's Surname:

Please review the following COVID-19 criteria and tick all that apply:

Does the patient have a positive COVID-19 infection?

Is the patient currently quarantined for potential COVID-19 infection?

Is the patient a healthcare or aged care worker with a headache, myalgia, stuffy nose, nausea, vomiting or diarrhoea?

Has the patient had close contact in the past 14 days with a COVID-19 confirmed case, or have been in a known cluster location (i.e. aged care facility)?

Yes

1. Does the patient require active clinical monitoring/care or clinical supervision during transport?

Yes No

1a. IF YES to question 1, "Is oxygen required?"

1b. IF YES to question 1a, Does this relate to an unchanged chronic condition, or new/acute?

Unchanged New/Acute

2. Does the patient have impaired cognitive functioning (such as dementia or delirium) requiring supervision?

3. Does the patient's chronic condition require monitoring during transport?

Yes

4. Does the patient have an illness or disability that precludes them from utilising any other form of transport?

Yes

SELECT ONE OF THE FOLLOWING FORMS

Please make sure you've completed page 1 and one of the following form, and return both page 1 and the following form of your choice.





PATIENT INFO





REQUEST FOR CLINIC TRANSPORT SERVICES VER. 2.0

Patient's Given Name:						
Patient's Contact Number:	DOB:	Age:	Gender: Male	Female	X (Unspecified/Indeterminate	
Booking Facility:	C	Contact Name:	Contact Phone #:		Contact Fax #:	
Pick-Up Date/Day:	P	rick-Up Time*: (must be > 1 hour prio	r to appt time) Appointment	Гіme:		
Pick-Up Location: Include full address (a	nd name of facility if app	1.)			Ward/Dept/Residence:	
Destination: Include full address (and name	e of facility if appl.)				Ward/Dept/Residence:	
Authorising Practitioner:						
Medical Diagnosis: (relating to transport)						
Purpose of transport: (e.g. x-ray)						
Infectious Disease: (please specify)						
Select one platform only: If a stretche	r is required, please use th	ne Patient Transport online booking form	at neptbookings.ambulance.vic.gov.	.au		
Walker Patient is able to walk and climb three ste	ps unaided. Pat	alker Assist tient is able to walk and climb three steps tient is able to step transfer.	with assistance. Patient moment be on which are the control of the	Wheelchair Hoist Patient mobility is confined to a wheelchair and transport must be completed in a hoist equipped vehicle. Patient must have own wheelchair		
Guide/Assistance Dogs (with declar Other (please specify)	aration) Four	Wheel Frame Wheelchair				
Responsible Party (Billing):						
DVA Pension/HCC	Subscriber	TAC WorkCo	over IHT			
Number:						
Public Hospital Outpatients Appointr Transports to/from Specialist Patient Clinics of please note that an UR number is not an Orde	or Health Independence F			d will not be pro	cessed without an order number –	
Going for admission: Retu	ırn Trip: Yes		Primary Carer (Note – other esco	rts and/or family	cannot be transported due to COVID-19	





RENAL DIALYSIS PATIENT BOOKING FORM

For Quarter Ending:	March	Jun	e September	Dece	mber					
Dialysis Days: Mo	n Tue	V	Ved Thurs	Fri	Sat	Sun				
Recurring Booking:	Yes	No	Commencement I	Date:			End Date:			
Patient's Given Name:					Pati	ent's Surname:				
Patient's Contact Numl	ber:		DOB:		Age:		Gender: Male	Female	X (Unspecified/Indeterminate)	
Contact Name:			Contac	Contact Phone #: Contact Fax a			× #:	Appointment Time:		
Return Trip Required:	Yes	No	Suitable for	Multi Load: (<mark>lf not,</mark> pleas	e specify below▼)	Dialysis Usu	ally Takes: (Hou	rs)	
Pick-Up Location: Include	de full address	(and nam	ne of facility if appl.)							
Current Diagnosis:	t Diagnosis: Receiving Dialysis Unit:									
Medical History:	Infectious: (If yes specify) Yes No									
Patient Weight: <	160 kg	160 –	230 kg 230	+ kg						
Select one platform on	ly: If a streto	her is requ	uired, please use the Pa	tient Transport	online book	ing form at neptbookings.a	mbulance.vic.gov.a	<u>u</u>		
Walker Patient is able to walk and climb three steps unaided.		ded. Patient	Walker Assist Patient is able to walk and climb three steps with assistance. Patient is able to step transfer.			Patient mob	Wheelchair Hoist Patient mobility is confined to a wheelchair and transport must be completed in a hoist equipped vehicle. •			
							Patient m	nust have own	wheelchair	
Guide/Assistance De	ogs (with de	claration) Four Whe	el Frame	Whe	elchair				
Other (please specif	y)									
Name of Authorising Nephrologist:		Resp	Responsible Party: (Please specify one of the following)			ng)	Number:			
			1	Pension	DVA	AV Membership	Hospital			
Signature:				Authorising Dialysis Hub/Satellite:						

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^{*} Please note that by using this booking form you acknowledge that the patient has a bona fide medical reason for requiring transport by Ambulance Victoria Non-Emergency Patient Transport.