

CLIENT INTAKE FORM TRANSPORT ONLY

PLEASE NOTE

This form is for clients only using pick up and drop off supports.

PERSONAL INFORMATION					
First Name			Surname		
Preferred Name			Date Of Birt		
If under 18, or requ	ire assistan	ce to complete fori	m, nominate a parent /	D D M M Y Y caregiver to complete this form	
Parent / Caregiver name					
Full Address					
City / State			Postcode		
COVID Vaccinated	Yes	No	Flu Vaccinat	ed Yes No	
Gender	Male	Female	Other		
Phone			Mobile preferre	d for SMS Notifications	
E-Mail					
Doctor Name			Contact		
Disability	PHYSICAL	NTELLECTUAL COG	NITIVE NEUROLOGICAL	VISUAL HEARING PSYCHOSOCIAL	
Diagnosis / Additional Information					
-			ICK WALKING FRAME OTHER:	WHEELCHAIR (MANUAL) WHEELCHAIR	
ls there any known					
known behaviours / triggers our team should be aware of?					
Living	SIL ALONE	PARTNER PARE	NTS FRIEND SHARE H	IOUSE	

THANK YOU FOR YOUR INFORMATION



CLIENT INTAKE FORM

SERVICES / SUPPORTS REQUIRED

TRANSPORT

Transport For (please circle types of transport required)	MEDICAL APPOINTMENTS SHOPPING PERSONAL APPOINTMENTS SOCIAL ACTIVITIES Our appointment transport services are door to door						
Approx Appointments Per Week	0 - 3 A Week	3 - 5 A Week	5+ A Week	5+ A Week			
Support Worker	l need a support	worker to accompa	ny me I h	ave my own support workers			
Medication Requirements	lf you require our team to administer any medication, please attach the Assistance With Medications form						
Driver Preference	Male	Female	No preferenc	e			
Assistance Required getting into vehicle Are you OK with group travel? (eg.	Yes Type of ass	sistance?		No			
other clients in the same vehicle)							
Specific requirements /							
info our driver will need (eg.							
gate code / long driveway etc)							

EMERGENCY CONTACTS

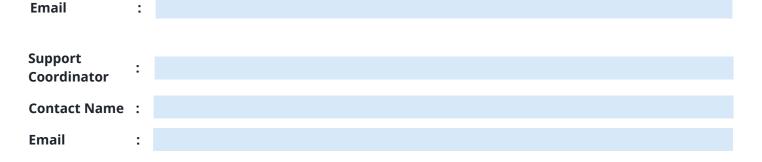
Full Name		
Contact No		
Relationship		
to you		
Full Name		
Contact No		
Relationship		
to you		

THANK YOU FOR YOUR INFORMATION



CLIENT INTAKE FORM

N DIS PLAN INFORMATION NDIS No : Plan Type : Self Managed Plan Managed NDIA Managed



SIGNATURE

I understand that;

- These records are owned by 2 Assist, please refer to our privacy policy for information on how data is stored
- This information collected is used to register my interest in utilizing services offered by 2 Assist
- A signed service agreement is required to start any support services with 2 Assist
- I can request a copy of this information at any time
- Information provided is used to register my interest in utilizing services offered by 2 Assist and will form the basis of a service agreement
- Information within this form may be shared with other staff within the organisation as required by staff in the completion of their duties
- Records are archived for a set period of time according to policy & procedure
- All information obtained will not be shared outside the organisation unless required by law, or by written request by myself.

To the best of my knowledge, the information provided is true and correct:

Client Name	
Parent / Caregiver Name	
Client Signature (or signature of parent/caregiver)	
Date Signed	

THANK YOU FOR YOUR INFORMATION

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