2 ASSIST
it's why we exist

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 Birth D D M M Y Y

If under 18, or require assistance to complete form, nominate a parent / caregiver to complete this form

Parent / Caregiver name

Full Address

City / State

Postcode

COVID Vaccinated Yes No

Flu Vaccinated Yes No

Gender Male Female Other

Phone *Mobile preferred for SMS Notifications*

E-Mail

Doctor Name

Contact

Disability PHYSICAL | INTELLECTUAL | COGNITIVE | NEUROLOGICAL | VISUAL | HEARING | PSYCHOSOCIAL

Diagnosis / Additional Information

Mobility Aids Used WHEELIE WALKER | WALKING STICK | WALKING FRAME | WHEELCHAIR (MANUAL) | WHEELCHAIR (ELECTRIC) | MOBILITY SCOOTER | **OTHER:** ______________________

Is there any known behaviours / triggers our team should be aware of?

Living SIL | ALONE | PARTNER | PARENTS | FRIEND | SHARE HOUSE

2 ASSIST
it's why we exist

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
☐ ***I need a support worker to accompany me*** ☐ ***I have my own support workers***

Medication Requirements
If you require our team to administer any medication, please attach the Assistance With Medications form

Driver Preference
☐ **Male** ☐ **Female** ☐ **No preference**

Assistance Required getting into vehicle
☐ **Yes** **Type of assistance?** ________ ☐ **No**

Are you OK with group travel? (eg. other clients in the same vehicle)
☐ **Yes** ☐ **No**

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 ________

CLIENT INTAKE FORM

2 ASSIST
it's why we exist

NDIS PLAN INFORMATION

NDIS No :

Plan End Date :

Plan Type : Self Managed Plan Managed NDIA Managed

Plan Manager :

Contact Name :

Email :

Support Coordinator :

Contact Name :

Email :

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