PASSENGER NAME walsall commi **ADDRESS CENTRE ATTENDING** Your assistance is sought in completing this form to enable us to address and accommodate the specific needs of the client when travelling If you are unsure how to respond to any of the questions asked or in turn would prefer the assistance of a member of staff in completing this form please contact office staff on 01922 685555 who will be happy to oblige. **HOME STATUS** (Please confirm the home environment of the client) Lives alone Lives with Family Sheltered Property Care / Rest Home PROPERTY TYPE (Please confirm the type of home the client lives in) Flat (Floor Level) House Bungalow Is the client able to negotiate stairs / steps unaided Yes If No, Give details No Are their any obstacles / barriers that may impair access to / from the client's home e.g., dog, locked gate, shared intercom access to flats, etc No Yes If Yes, Please explain **EMERGENCY CONTACTS** In the event of the client being taken ill or being involved in an accident please give the names of two people the client would wish us to contact

Relationship

PASSENGER PROFILE

Name

Phone No. (Mobile Preferable)

MOBILITY and CARE STATUS (tick as appropriate) ON RETURNING HOME Does the client need to be handed over to another person Yes No IF YOU TICK NO WE WILL ASSUME THAT THE CLIENT CAN BE LEFT IN THEIR HOME **UNATTENDED** The client walks with the aid of a frame or stick The client is able to walk unaided The client is a wheelchair user Client requires additional support in walking If No, what additional support is needed Can the client take responsibility for their own medication and personal posessions Yes No Does the client require assistance to fasten their seatbelt Yes No Does the client suffer travel sickness on a regular basis? Yes No MOBILITY AIDS (Either used or accompanying the client) Wheelchair Please state Make & Model Remain in the wheelchair whilst on the minibus Does the client prefer to :-Transfer to a vehicle seat on the minibus Walking Frame Oxygen Other (Please state **MEDICAL CIRCUMSTANCES** Is there any condition medical or otherwise that we need to be made aware of in order to assist us in caring for the client? Any information provided will not be divulged to any 'third party' and will only be used for the purpose it is intended. Storage and use of such information will be in accordance with the requirements of GDPR. Form completed by Relationship to client Date completed Please give a contact number should we wish to contact you about any of the above information Phone no.

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