



Ambulance

Metropolitan Ambulance Service



NON-EMERGENCY TRANSPORT REQUEST FORM

Stretcher Transport Bookings:
 Fax: 1300 366 314 Phone: 1300 366 313

Clinic Transport Bookings (walker/wheelchair):
 Fax: 1300 361 929 Phone: 1300 360 929

| | | | | | | | |
|---|--|----------------------|--|--|--|---|--|
| Booking Facility: | | Contact Name: | | Contact Phone No: | | Contact Fax No: | |
| Pick-Up Day: | | Pick-Up Date: | | Pick-Up Time: <i>(Must be at least 1 hour prior to appointment time)</i> | | Appointment Time: | |
| Authorising Practitioner: | | | | Pick Up Location Phone: | | | |
| Pick-Up Location: (Include full address) | | | | | | Ward/Dept/Residence: | |
| Destination: (Include full address) | | | | | | Ward/Dept/Residence: | |
| Patient's Surname: | | | Given Name: | | | Age: | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Acuity/Mobility: * Refer NEPT Regulations <input type="checkbox"/> Stretcher Low Acuity* <input type="checkbox"/> Stretcher Medium Acuity* <input type="checkbox"/> Stretcher High Acuity* <input type="checkbox"/> Wheelchair Confined <input type="checkbox"/> Walker Assist (Wheelchair assist to/from vehicle) <input type="checkbox"/> Walker (Can ambulate and climb 3 steps with assistance) | | | | | | | |
| Current Medical Diagnosis: | | | | | | | |
| Infectious Disease: Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Details of Infectious Status: | | | | | | | |
| Patient For: <input type="checkbox"/> Admit/Discharge <input type="checkbox"/> Day Surgery <input type="checkbox"/> Other (specify) | | | | Responsible Party: <input type="checkbox"/> Patient Pension/DVA: _____ <input type="checkbox"/> WorkCover/TAC Claim/Ref No.: _____ <input type="checkbox"/> Other Details: _____ | | | |
| Patient For: <input type="checkbox"/> IHT <input type="checkbox"/> Outpatient* <input type="checkbox"/> Pre/Post Hospital Care Procedure* (specify) | | | | Responsible Party: Hospital <i>*Receiving Public Hospital must request & Authorise</i> Hospital Order No.: _____ | | | |
| Special Requirements: <input type="checkbox"/> Cardiac Monitor <input type="checkbox"/> O ² – Litres/minute: _____ <input type="checkbox"/> I/V Insitu – Contents: <input type="checkbox"/> Heparin <input type="checkbox"/> G.T.N. Other: _____ | | | | Double Load Yes <input type="checkbox"/> No <input type="checkbox"/> | | Escort: Medical <input type="checkbox"/> Family* <input type="checkbox"/> <i>(*Family Subject to Vehicle Capacity)</i> Specify Number: _____ | |
| Equipment/Mobility Aids: (specify) | | | Return Trip: Yes <input type="checkbox"/> Est Time: No <input type="checkbox"/> | | | Patient Weight: <input type="checkbox"/> < 160kg <input type="checkbox"/> 160-230kg <input type="checkbox"/> 230kg+ | |

By using this booking form you acknowledge that the information supplied is in accordance with NEPT Regulation effective 1 February 2006. You further agree that the patient has been fully assessed and that the acuity level documented is an accurate reflection of the patient's current condition. You therefore give consent that the patient is suitable for non emergency patient transport. Further clarification/details of the NEPT Regulations and Clinical Practice Protocols may be accessed at www.health.vic.gov.au.