AmbulanceVictoria

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

Metropolitan	Walker, Walker Assist and Wheelchair (Metro Transfers Only) | **Phone:** 1300 360 929 (enquiries/cancellations) | **Fax:** 1300 361 929 (bookings)

PATIENT INFO

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?

◯ Yes ◯ No

Is the patient currently in isolation due to tier 1 exposure?

◯ Yes ◯ No

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 ◯ No

FORM SELECTION

SELECT ONE OF THE FOLLOWING FORM

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.

REQUEST FOR CLINIC TRANSPORT SERVICES
Click Here to Page 2

RENAL PATIENT BOOKING FORM
Click Here to Page 3

AmbulanceVictoria

REQUEST FOR CLINIC TRANSPORT SERVICES VER. 1.0

Is it clinically necessary for the patient to travel by Ambulance? See over for rules ◯ Yes ◯ No

Does the patient require active clinical monitoring/supervision during transport? See over for rules ◯ Yes ◯ No

Patient's Given Name:

Patient's Surname:

Patient's Contact Number:

DOB: 08/08/1990

Age: 31

Gender: ◯ Male ◯ Female ◯ X (Unspecified/Indeterminate)

Booking Facility:

Contact Name:

Contact Phone #:

Contact Fax #:

Pick-Up Day:

Pick-Up Time*: (must be > 1 hour prior to appt time)

Appointment Time:

*If the pick-up time is prior to 07:00 and the patient is being transported from a Regional area, by submitting this form I acknowledge that I have spoken to the receiving facility and have confirmed that they will accept the patient if they are running late. All bookings prior to 07:00 are subject to review and approval by ESTA before the booking can be confirmed.

Pick-Up Location: Include full address (and name of facility if appl.)

Ward/Dept/Residence:

Destination: Include full address (and name of facility if appl.)

Ward/Dept/Residence:

Authorising Practitioner:

Practitioner Phone #: (Pub Hosp appt only)

Medical Diagnosis: (relating to transport)

Purpose of transport: (e.g. x-ray)

Infectious Disease: (please specify)

Select one platform only: If a stretcher is required, please fax to 1300 366 314.

◯ **Walker**
Patient is able to walk and climb three steps unaided.

◯ **Walker Assist**
Patient is able to walk and climb three steps with assistance.
Patient is able to step transfer.

◯ **Wheelchair Hoist**
Patient mobility is confined to a wheelchair and transport must be completed in a hoist equipped vehicle.

Does the patient have a wheelchair? ◯ Yes ◯ No

☐ Guide/Assistance Dogs (with declaration) ☐ Four Wheel Frame ☐ Wheelchair

☐ Other (please specify)

Responsible Party (Billing):

◯ DVA ◯ Pension/HCC ◯ Subscriber ◯ TAC ◯ WorkCover ◯ IHT

Number:

Public Hospital Outpatients Appointment for patient under Pension, HCC or IHT: Hospital Order Number:

Transports to/from Specialist Patient Clinics or Health Independence Programmes must be booked and authorised by the receiving hospital and will not be processed without an order number – please note that an UR number is not an Order Number

Going for admission: ☐ **Return Trip:** ◯ Yes ◯ No **Escort:** ☐ Essential Primary Carer (Note – other escorts and/or family cannot be transported due to COVID-19 and must make alternate arrangements)

AmbulanceVictoria

RENAL PATIENT BOOKING FORM

For Quarter Ending: ☐ March ☐ June ☐ September ☐ December

Dialysis Days: ☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

Recurring Booking: ◯ Yes ◯ No **Commencement Date:** **End Date:**

Patient's Given Name: **Patient's Surname:**

Patient's Contact Number: **DOB:** 14/12/1980 **Age:** 40 **Gender:** ◯ Male ◯ Female ◯ X (Unspecified/Indeterminate)

Contact Name: **Contact Phone #:** **Contact Fax #:** **Appointment Time:**

Return Trip Required: ◯ Yes ◯ No ☐ **Suitable for Multi Load:** (If not, please specify below▼) **Dialysis Usually Takes:** (Hours)

Pick-Up Location: Include full address (and name of facility if appl.)

Current Diagnosis: **Receiving Dialysis Unit:**

Medical History: **Infectious:** (If yes specify) ◯ Yes ◯ No

Patient Weight: ◯ < 160 kg ◯ 160 – 230 kg ◯ 230+ kg

Select one platform only: If a stretcher is required, please fax to 1300 366 314.

◯ **Walker**
Patient is able to walk and climb three steps unaided.

◯ **Walker Assist**
Patient is able to walk and climb three steps with assistance.
Patient is able to step transfer.

◯ **Wheelchair Hoist**
Patient mobility is confined to a wheelchair and transport must be completed in a hoist equipped vehicle.
▼
Does the patient have a wheelchair? ◯ Yes ◯ No

☐ Guide/Assistance Dogs (with declaration) ☐ Four Wheel Frame ☐ Wheelchair

☐ Other (please specify)

Name of Authorising Nephrologist: **Responsible Party:** (Please specify one of the following) ☐ Pension ☐ DVA ☐ AV Membership ☐ Hospital **Number:**

Signature: **Authorising Dialysis Hub/Satellite:**

* 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.