PLEASE forward at least 2 ... to guarantee travel

FAO Ruth Murray 8140371

Health Service Executive Ambulance Service Dublin

ADVANCED BOOKING AND ASSESSMENT FORM FOR PATIENT TRANSPORT

This form must be completed by an appropriate health care professional, e.g. Doctor, Public Health Nurse, Physiotherapist, Occupational Therapist or other Medical Source

From: _____ Phone No. _____
Please Type in Name of Health Centre (font size 16) — Type Phone No. font size 16

Transport Requested By _____ Fax No. _____
Name & Title of Health Care Professional — Type Fax No. font size 16

This form must be FAXED to the Advanced Booking Office, Ambulance Command and Control Centre, Maudlins Industrial Estate, Monread, Naas, Co. Kildare, No later than 12:00 Mid-Day on the previous working day (Monday-Friday) on (045) 876046.

Patient Booking Details and Needs Assessment

Has Patient Travelled Previously Yes☐ No☐ **Previous Booking Number** _____ If known

Journey Type: Single☐ Return☐ Repeat Booking☐ Admission☐ Discharge☐

Home Phone No. ..... Mobile ..... D.O.B...../...../.....

Surname ..... First Name .....

Address: ....

....

Hospital Address: ..... Phone: .....

Clinic Type: ..... Consultant: .....

Mobility:

Stretcher ..... S	☐	Hospice/admission (ambulance case)
Chair C	☐	Needs to be carried out (ambulance case)
Own Wheelchair C2	☐	Wheeled out by one person, has wheelchair access
Electric Wheelchair C3	☐	Needs to travels in own wheelchair (secured)
Walking .....W	☐	Able to walk or be linked
Wheelchair Transferable W T	☐	Able to use standard transport with wheelchair folded up
Walking with Frame.....W F	☐	Walks with frame, crutches etc.

Escort Yes☐ No☐ **Start Date** ..... **End Date** .....

App. Time ..... **Frequency:** Weekly M☐ T☐ W☐ T☐ F☐
Fortnightly M☐ T☐ W☐ T☐ F☐

Patient Profile and Special Needs relative to Transport request i.e. Insulin Dependant Diabetic, Visually Impaired, May Need Oxygen, Fasting etc. _____

_____

State reason why above patient cannot use public or family transport _____

_____

I certify that in my professional opinion the above named is unable to use public/family transport and therefore requires ambulance service transport Signed .....
Name & Title of Health Care Professional

Eastern Regional Ambulance Service Booking Office Phone 866666 Fax 876046