

Travel Training Service

Referral Package

This referral package consists of four parts and each part is explained below.

Part One - *Consent Form*

This must be filled out before the applicant can be considered for Travel Training. The form is acknowledging the client's consent for their information to be shared between the Travel Training Service and the referring Agency/person.

Part Two - *Referral Form*

Please fill out as much information as possible as this will assist us in identifying transport options for the applicant prior to our first contact.

Part Three - *Fitness Assessment for the Travel Training Service*

This is to determine client's capacity to using public transport independently. If any medical conditions or concerns are not controlled, then a doctor's consent may be required.

Part Four - *Client Survey*

There is a client survey that we ask to be completed which can be filled out when travel training commences, and a feedback form once training has been completed. The clients' privacy will be maintained as only the data is used for collection and recording.

The Travel Training Service does not teach road safety or money handling skills as it is expected that the applicant will have these skills prior to participating in the service.

Once the information has been compiled please forward the completed forms by email, fax, or post to the above address. If you have any questions ask to speak with Deidre Baker, the Travel Training Educator.



Cottage 3/80 Park Road, East Nowra NSW
PO Box 672 Nowra NSW 2541

ABN 96 928 772 506

Phone: 02- 44236044 Fax: 02- 44236394 Email: admin@scts.org.au

Travel Training Consent Form

I(**Print name**) hereby give permission for Shoalhaven Community Transport Travel Training Service, to receive my personal information and share the information with the referring organisation/person. This information will not be shared with anyone who I have not given permission to.

(Please circle Yes or No)

The referring organisation/person Yes/No

.....

Family member Yes/No

.....

I would like a copy of my Travel Training Plan and Final Travel Training Report/ Assessment to be forwarded to the following people including myself.

The referring organisation/person Yes/No

Family member Yes/No (Details)

Is there anyone else you would like your information sent to Yes/No

If yes please provide contact details

.....

Signed Dated.....

Information given will be treated as confidential and will not be released to a third party without prior consent from the client.

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Referral Form for the Travel Training Service

Referee Details

Organisation

Name

Position

Contact Details

Email address

Applicant Details

Gender (Please tick box) Male Female

Applicant's name

Date of Birth

Nationality/Language spoken

Residential Address.....

Phone Number

Pension/Concession type/Eligibility

Medical
Conditions/Disability/Illnesses.....
.....

Reasons for referral to the Travel Training Service
.....
.....

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Assessment of Fitness to participate in the Travel Training Service

This form is to be completed by the Referring Organisation or the Travel Training Educator.

Name of person completing this form

Date

Depending on the outcome of the assessment the applicant may be required to obtain their Doctor's approval prior to commencement of the Travel Training Service. This is due to possible concerns of the client's ability to travel on public transport independently.

Vision

| | | | |
|--|-----|----|-----------|
| Requires glasses at all times | Yes | No | Not Known |
| Blind in one or both eyes | Yes | No | Not Known |
| Will this impact on their ability to travel unaided? | Yes | No | Not Known |

Hearing

| | | | |
|--|-----|----|-----------|
| Completely deaf | Yes | No | Not Known |
| Partially deaf | Yes | No | Not Known |
| Requires hearing aids at all times | Yes | No | Not Known |
| Will this impact on their ability to travel unaided? | Yes | No | Not Known |

Mobility Aids

| | | | |
|---|-----|----|-----------|
| Is the person competent using their mobility aid. | Yes | No | Not Known |
|---|-----|----|-----------|

Function/cognitive ability

| | | | |
|--|-----|----|-----------|
| Is there a possibility of the client falling while using public transport? | Yes | No | Not Known |
|--|-----|----|-----------|

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Mobility Concerns

| | | | |
|--|-----|----|-----------|
| Recent fall | Yes | No | Not Known |
| Unsteady on their feet | Yes | No | Not Known |
| Suffers from dizziness | Yes | No | Not Known |
| Will this impact on their ability to travel unaided? | Yes | No | Not Known |

Medical Conditions

| | | | |
|--|-----|----|-----------|
| Has the client been diagnosed with: | | | |
| Diabetes | Yes | No | Not Known |
| High blood pressure/hypertension | Yes | No | Not Known |
| Low blood pressure/hypotension | Yes | No | Not Known |
| Epilepsy | Yes | No | Not Known |
| Asthma | | | |
| Other..... | Yes | No | Not Known |
| Will this impact on their ability to travel unaided? | Yes | No | Not Known |

Substance dependence

| | | | |
|--|-----|----|-----------|
| Alcohol | Yes | No | Not Known |
| Drug | Yes | No | Not Known |
| Will this impact on their ability to travel unaided? | Yes | No | Not Known |

Mental disorders

| | | | |
|--|-----|----|-----------|
| Has the client been diagnosed with a mental illness? | Yes | No | Not Known |
| Will this impact on their ability to travel unaided? | Yes | No | Not Known |

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If there are any other conditions or illnesses that may affect the client's ability to use the Travel Training Service, please list them.

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If any of the above conditions are not under control then approval from a medical professional needs to be obtained prior to commencement of the travel training service.

