R&D TRANSPORTATION SERVICE REQUEST - TCRC

Office: 1-800-966-7114 Fax: 1-805-484-0694

DATE:____________

CLIENT ____________ UCI # ____________ BIRTHDATE ____________ ☐ FEMALE ☐ MALE

SVC COORD ____________ OFFICE ____________ PH (incl. area code): ____________

☐ NEW SERVICE ☐ DELETE SERVICE ☐ COST ANALYSIS ☐ TRAVEL TRAINING ☐ RESPITE ☐ CHANGE IN SERVICE/CLIENT DATA

CHANGE TYPE: ☐ ADDRESS/PHONE ☐ PROGRAM ☐ DAYS/HOURS: ADD: ☐ AM ☐ PM CANCEL: ☐ AM ☐ PM

START DATE: ____________ TERM DATE: ____________ AUTHORIZING SIGNATURE ____________

CLIENT DATA

CLIENT'S AM ADDR: ____________

CLIENT'S PM ADDR (if different from a.m.): ____________

CLIENT'S PHONE (incl. area code): ____________ CONTACT ____________

CLIENT'S DESIGNATED EMERGENCY CONTACT: PH (incl. area code): ____________ CONTACT ____________

DESTINATION: ____________ PH (incl. area code): ____________ CONTACT ____________

ADDRESS (incl. city & zip code): ____________

DAYS OF ATTENDANCE: ☐ MON-FRI ☐ MON ☐ TUE ☐ WED ☐ THU ☐ FRI ☐ SAT ☐ SUN

HOURS OF ATTENDANCE: START ____________ END ____________ TYPE OF SERVICE: ☐ AM & PM ☐ AM ONLY ☐ PM ONLY

LIVES: ☐ INDEPENDENTLY ☐ SEMI-INDEPENDENT ☐ FAMILY ☐ CAREGIVER ☐ GROUP HOME

NAME OF GROUP HOME: ____________ MAY BE DROPPED UNATTENDED: ☐ YES – SIGNED RELEASE ATTACHED

CONSERVED: ☐ NO ☐ YES - CONSERVATOR: ____________ RELATION: ____________ PH: ____________

LANGUAGE (if other than English): ____________ SPEECH: ☐ NON-VERBAL ☐ BASIC ☐ MODERATE ☐ GOOD

AUDITORY: ☐ HEARING IMPAIRED ☐ DEAF SIGHT: ☐ IMPAIRED ☐ BLIND

BEHAVIOR DISORDER: ☐ NO ☐ YES FREQUENCY: ____________ DATE OF LAST INCIDENT: ____________

BEHAVIOR: ____________

SEIZURES: ☐ NO ☐ YES, TYPE: ____________ FREQUENCY: ____________ DURATION: ____________

DIAGNOSIS: ____________

ALLERGIES: ____________

MOBILITY (must check one): ☐ AMBULATORY ☐ WALKER ☐ CANE ☐ CRUTCHES ☐ OTHER:____________

WHEELCHAIR: ☐ MANUAL ☐ ELECTRIC ☐ OVERSIZED ☐ REQUIRES ATTENDANT – MGR APPROVAL: ____________

NOTE:____________

THIS SECTION FOR R&D USE ONLY

DATE RECVD ____________ SCHLD BY ____________ EFFECTIVE DATE ____________

	RTE	TIME	STP ID	VENDOR
AM				
PM				

PRGM NOTIFICATION: ____________

CLIENT NOTIFICATION: ____________

NOTE: ____________