Allinda's Care
& Companion Services

REQUEST FOR SERVICE FORM

Client Name .....

Address .....

..... Post code: .....

Phone Number ..... Mobile: .....

Email .....

Emergency Contact .....

Phone .....

Email .....

TYPE OF SERVICE:	
Attend Appointment	☐
Visit Family & Friends	☐
Attend Special Events	☐
Day Out	☐
Holidays	☐
Date Required:	**.....**
Start Time/expected finish time:	**Start..... Finish.....**
Destination:	**.....**

All information gathered by Allinda's Care & Companion Service is strictly confidential

IMPORTANT INFORMATION: Please circle your response

Property Access to pick & drop of Client: front door/back door steps/ramp

Mobility:

No aids	Cane	Walker	4 wheel walker	wheelchair

If you use a wheelchair are you able to transfer independently from chair to car? Yes/No

Do you have: **Hearing loss** Yes / No **Sight impaired** Yes / No

Do you have any Allergies? Yes / No

If Yes, please specify: .....

Do you have any **other medical conditions** that Allinda's Care & Companion Service may need to be aware of? Yes / No

If Yes, please specify: .....
.....
In the event of an emergency, are you Not for Resuscitation? Yes / No

I, (Printed Name).....
(client/family member/care giver)

(Signature).....
Understand agree that the information provided is accurate.

I, ...also have agreed to the cost involved for the nominated activity and will pay the Tax Invoice within 7 days after the service is provided by Allinda's Care & Companion Service, except for holidays. Additional forms are required and can be found in the "holiday" link.

Address for Payment: .....

.....Post code.....

Email: .....

All information gathered by Allinda's Care & Companion Service is strictly confidential