

TRANSPORTATION REQUEST AND PASSENGER INFORMATION

PASSENGER INFORMATION

Name of passenger _____ Age _____ Male/Female _____

Primary Physician _____ Date of birth _____

Care Facility (if applicable): _____ Facility phone _____

Home address _____ City _____ Zip _____

Phone _____ Phone #2 _____

Directions _____

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Uses fold-up wheelchair | <input type="checkbox"/> Uses cane | <input type="checkbox"/> Hearing impaired |
| <input type="checkbox"/> Transfers in/out of wheelchair independently | <input type="checkbox"/> Uses walker | <input type="checkbox"/> Visually impaired |
| | <input type="checkbox"/> Uses oxygen | <input type="checkbox"/> Memory impaired |

Requires assistance—Explain _____

Mask required to be worn by all people in the vehicle

Remind senior to have his/her ID and health insurance/Medicare card in his/her possession.

EMERGENCY CONTACT

Name _____ Relationship to senior _____

Phone _____ Alternate Phone _____

TRANSPORTATION REQUEST

Date _____ Pick up time _____ Appt time _____ Return Time _____

Destination/Purpose of trip _____

Address: _____

Driver assigned _____

Miles transported _____ Total miles driven _____

Ministry or church information given to passenger.

Driver NOTES _____

COMPLIMENTS OF: Koinonia Senior Care:

Enriching the lives of homebound seniors and their caregivers and encouraging our community to join us!

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