Specialist Healthcare Tasks Transport Service

Referral Form

Student Name	DOB	Age	Gender

Student Address: **Post Code:**	**Referred by:** (Name/Job Title): **Date of referral:** **Company Name:** **Contact Number:** **Contact Email address:**
Specialist Healthcare need:	
Destination 1 (School)	
Destination 2 (overnight short break, if applicable)	
Reason for training referral	
Is the training requirement urgent? (Please note the normal turnaround time for training to be delivered is 15 working days. Please state reasons for the urgency)	

Name of person to be trained	Date of birth	Job Title	Valid DBS in place?	Valid Passenger Assistant training? (Blue badge)

Any other relevant information:

Declaration:

I hereby confirm that the information I have provided above is correct and accurate.

The passenger assistants/drivers nominated for training have completed their Passenger Assistant training (blue badge) and have a valid DBS; or will do, prior to them being used to transport the above named student. I understand that failure to comply with this requirement could result in action being taken by Essex County Council.

Signed:

Print Name/Title:

Date:

Please send completed referrals to Provide.transporttraining@nhs.net

If you have a query regarding Specialist Healthcare Training, please contact the team using the email address above, or by ringing **03330 132598**

Office use only

Referral received date	
Date scanned and registered to S1	
Approved by nurse?	
Consent given?	
Valid care plan available?	
Risk assessment signed?	
Date training invite issued	