For Office Use Only

☐ WC
☐ OA
☐ HR

Date Received:_____ Staff Initials:____

Attach Photo Here

Trip Location: _____

Trip Date: _____

General Information

Traveler's Legal Name_____ Birth Date_____ Age_____

Street Address_____ City_____ State_____ Zip_____

Phone # ( ) _____ Sex: Male_____ Female_____

Airport of Choice (If not Minneapolis/St Paul, other fees may apply) _____

Passport Information (if applicable)

Name on Passport:_____ Passport Number:_____

Date Issued:_____ Expiration Date:_____ Country of Issuance:_____

Contact Information

Legal Guardian/Conservator Information

Name_____ Phone_____

Street Address _____ City_____ State_____ Zip_____

Relationship to Traveler_____

Residential Contact Information (If Applicable)

Name_____ Phone_____

Street Address _____ City_____ State_____ Zip_____

Relationship to Traveler_____

Communication Information

Please check one box for each question below. This person will receive hard copies of this information. Additional copies of this information can be sent via email. Please provide information at the end of this section if additional copies of materials are needed.

Send Billing Information to:	☐ Traveler	☐ Guardian/Conservator	☐ Residential Contact
Send Consents and Waiver to:	☐ Traveler	☐ Guardian/Conservator	☐ Residential Contact
Send Pre/Post Trip Materials to:	☐ Traveler	☐ Guardian/Conservator	☐ Residential Contact

**Pre/Post Trip Materials includes: Trip Itinerary, Packing Guide, Medication Envelopes/Packing Instructions, Luggage Tag, &Trip Picture Disc*

Name:_____ **Email Address:**_____

Information to be sent:_____

Staff to Traveler Ratio Please explain if other than 1:4 (additional fees may apply)

☐ 1:4 (or less) ☐ 1:1

Behavioral Concerns (Check all that apply):

If traveler has any behavioral concerns please complete the "Behavioral Supports" form.

_____ Hitting	_____ Refusal to leave an area	_____ Self Injurious
_____ Biting	_____ Crying for no apparent reason	_____ Yelling
_____ Eloping	_____ Throwing objects	_____ Swearing
_____ Vehicle Safety	_____ Refusal to take medications	_____ Inappropriate Sexual Behavior
		_____ No Behavioral Concerns

Other (Specify):

Medical History (Check all that apply)

_____ Heart Problems (please explaine below)
_____ High Blood Pressure
_____ Pacemaker
_____ Diabetes
Controlled: yes___ no___
Injections: yes___ no___
Blood Testing: yes___ no___
_____ Seizure Disorder
Controlled: yes___ no___
PRN Medication: yes___ no___
_____ Asthma
_____ Pulmonary Disease
_____ Communicable Disease
_____ Blind
_____ Deaf
_____ Edema
_____ Headaches/Migraines
_____ Traumatic Brain Injury
_____ Stomach Problems or Ulcers
_____ Uses Portable Oxygen (Please describe device below)
_____ Catheter (please explaine below)
_____ Ostomy (please explaine below)

Desription of above or Other not listed (Specify):

Lifestyle Choices:

_____ **Uses Tobacco Products**

_____ **Consumes Alcohol**

*It is Hammer Travel's policy that no more than two alcoholic beverages are consumed daily

Allergies

Does Traveler have any allergies? **Yes** **No** **If Yes, please describe below:**

Medicines:_____

Food:_____

Other:_____

Describe Allergic Reaction: _____

_____

Diet

Is Traveler on a Special Diet? **Yes** **No**

If Yes, please describe:

Toileting

Does Traveler Need Assistance Toileting? **Yes** **No**

If Yes, please describe:

Daily routines

Usual Bed Time:_____ **Preferred activity length:**_____

Naps throughout day: **Yes** **No** **Enjoys shopping:** **Yes** **No**

Slow to get started in the AM: Yes No

Is alright in larger group settings: Yes No

Difficulty going to bed: Yes No

Is alright in loud settings: Yes No

Additional Information (Check all that apply. If you check "Needs Assistance" please describe below)

Eating

_____ No Assistance Needed
_____ *Needs Assistance
_____ Slow eater
_____ Needs food cut into pieces
_____ Needs food pureed

Vision

_____ No Difficulty Seeing
_____ Wears Glasses
_____ Wears Contact Lenses
_____ Traveler is Blind

Dressing

_____ No Assistance Needed
_____ *Needs Assistance

Swimming

_____ Independent
_____ Needs life jacket/floats
_____ Needs to stay waist deep
_____ Can't swim

Speaking

_____ No Difficulty Speaking
_____ Speaks Slowly
_____ Uses computer/machine to speak
_____ Is Nonverbal

Bathing

_____ No Assistance Needed
_____ *Needs Assistance
_____ Needs roll in shower
_____ Needs Shower bench/chair

Hearing

_____ No Difficulty Hearing
_____ Need to speak slowly
_____ Needs Statements Repeated
_____ Wears Hearing Aid/s
_____ Traveler is Deaf

Ambulation

_____ No Help Needed
_____ Needs Help on unstable ground
_____ Hand over hand assistance
_____ Uses a walker
_____ Uses a manual wheelchair
_____ Uses an electric wheelchair
Battery type _____
_____ Wheelchair used for long distances only

If wheelchair is used:

_____ Requires a wheelchair accessible van
_____ Can self transfer
_____ Needs assistance to transfer
_____ Can bear weight
_____ Traveler is a 2 person transfer
Traveler's weight _____
_____ Uses a lift at home

*please describe below how traveler is transferred, assistance needed, etc.

***Additional Information (assistance needed, routines, likes/dislikes, etc.):**