Rides to Recovery Referral Form

ALL REFERRALS MUST BE RECEIVED NO LESS THAN 48 BUSINESS HOURS BEFORE THE TRANSPORTATION IS NEEDED.

PERSONS TO BE TRANSPORTED

Date of request______________

Client Name (F) ________________________ (L)___________________________ DOB________________

Phone number (____)__________________ Address ____

DESTINATION ADDRESS

Name of Business ____________________________ Street Address _______________________________

City ______________State _____ Zip code _________ **Is client returning to same location?** _______

TRIP DETAILS (*Check All That Apply*)

Trip Type		**Employment**	
One-Way		**Recovery Support**	
Round-Trip		**Probation/Legal Entity**	
Multi-Leg		**DSS**	
		Food Source	
		Education	
		Other:	

How many riders?		
Will there be a service animal?		
Does the client use:		
Can the client transfer without assistance?	*Crutches*	
	Walker	
Yes ☐	*Cane*	
No ☐	*Wheelchair*	

APPOINTMENT SCHEDULE

Day(s) of the Week		*Start Date*	*Start Time*	*End time*	*Is this a recurring trip?*	*End Date*
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						

Is there a specific pick-up time required? _______________ **How long will the trip take?** _______

Special Instructions/Details: ____

Recovery Coach/Peer Advocate/Case Worker ____

Agency Representing _________________________ **Phone** _______________________________

Email ____________________________________

Return to: STLRTR@volunteertransportation.org or OswegoRTR@volunteertransportation.org

Requesting agency use only: *Date Confirmed by VTC* ___________ *Staff Confirming* ____________________