

BOOKING REQUEST DETAILS



Today's Date: _____

Where did you hear about us? _____

Location of patient accommodation: _____

Date of arrival: _____ (Arrivals cannot be before 2pm)

Date of departure: _____ (Departures must be no later than 10am)

PERSONAL DETAILS

Name: _____ D.O.B: _____

Home Address: _____

Phone: (h) _____ (w) _____ (m) _____

Drivers Licence #: _____

TREATMENT DETAILS

Type of Treatment: _____

Length of Treatment (if known): _____

Duration of Stay: _____

Number of Persons: _____

Names of Persons: _____

Name of person authorised to refer: _____

Signature of person authorised to refer: _____

Hospital from where referred: _____

Have you applied for PATS / IPTAAS / VPTAAS / QLD Hospital? _____
(Your patient travel must be completed and signed by your referring doctor)

METHOD OF PAYMENT (In case of loss of items or damage to the property during your stay)

Name on Card: _____

Credit Card Type: VISA MasterCard American Express Diners

Credit Card Number: _____

Expiry Date: _____

The person/s staying at the residence are joint and severally liable for any damages to the house and /or its contents in accordance with the terms and conditions of occupants which are available upon request.

Signature: _____

Please submit your BOOKING REQUEST DETAILS either by:

Fax: (08) 8235 7099

Post: Level 2, 255 Pulteney Street
Adelaide SA 5000

or email directly to our office: sjohnson@cancerresearch.org.au

Internal use only:

Amount to be charged for damage/loss \$ _____ Date _____

Item lost/damaged: _____