TARC3 Medical Form

(Cognitive Limitations or Psychological Conditions)

Name of Applicant _____

Address _____ **Apt #**_____

City _____ **Zip Code**_____ **Phone**_____

MEDICAL RELEASE

I (applicant signature)_____, do hereby authorize my physician, medical clinic, or health care provider, to release to the Transit Authority of River City any medical information related to my condition that will assist in the determination of my ability to ride the city bus.

To Be Completed by a Licensed Health Care Professional Only

This medical information is being requested by TARC to determine the applicant's ability to safely and effectively use the city bus system.

Applicant has been a patient of mine since ____/____/____

Date of most recent contact with the patient ____/____/____

Cognitive Limitations

1. What is the formal diagnosis of the applicant's condition?

_____

2. Does the applicant have any specific behavioral problems?

   ☐ Yes Describe_____

   ☐ No

3. Is the applicant able to travel alone?

   ☐ Yes

   ☐ No

   If no, does the applicant need assistance to travel safely in the community?

   ☐ Yes

   ☐ No

4. Does the applicant have the ability to follow directions?

   ☐ 1-Step Directions

   ☐ 2-Step Directions

   ☐ 3-Step Directions

5. Is the applicant able to tell time and to follow a schedule?

☐ Yes

☐ No

6. Would the applicant know what to do if he/she became lost while out in the community?

☐ Yes

☐ No Explain _____

7. Would the applicant be able to recognize and avoid dangers he/she might encounter when traveling in the community?

☐ Yes

☐ No

8. Does the applicant have the ability to safely cross streets?

☐ Yes

☐ No Explain_____

9. Does the applicant possess cognitive deficits in any of the following?

Please check all that apply:

☐ Problem Solving

☐ Short-term Memory

☐ Attention

☐ Processing

☐ Foresight/Planning

☐ Safety Awareness/Judgment

How would these deficits prevent the applicant from being able to safely use regular city buses?

_____

_____

10. If the applicant received travel training, do you feel he/she would be able to safely and effectively use regular city buses?

☐ Yes

☐ No

Information on Psychological Condition(s)

1. What is the formal diagnosis of the applicant's condition? (DSM-IV)

_____

2. What is the prognosis of this condition for independent function?

_____

_____

3. Has the applicant been prescribed medications for his/her condition?

☐ Yes

☐ No

If yes, does this medication allow the applicant to function safely in the community?

☐ Yes

☐ No

4. Has the applicant recently had a decline in function due to an adjustment in medication?

☐ Yes

☐ No

5. Does the applicant experience auditory or visual hallucinations?

☐ Yes

If yes, how do the hallucinations impair the applicant's ability to function in the community?_____

☐ No

6. Does the applicant have anxiety or panic attacks in closed spaces or crowded places?

☐ Yes. Please Explain_____

_____

☐ No

7. Are there life skills that the applicant lacks that would prevent him/her from safely using regular city buses?

☐ Yes

☐ No

If yes, please explain:

_____

_____

8. *TARC3 (paratransit) drivers assist individuals* from the door of their origin to the van; and from the van to the door of their destination. Does the applicant require additional assistance from a PCA? ___Yes ___No If "yes", please describe the type of assistance needed:

_____

_____

_____

If you feel it would be helpful, feel free to provide a copy of any neuropsychiatric or cognitive testing that may assist TARC in determining the applicant's ability to safely and effectively use regular city buses. (*Note: TARC offers travel training at no charge.*)

Name of Medical Professional Completing this Form:

Print Name _____

Professional Title _____

Area of Professional Specialization: _____

"I certify that the information contained herein is true and correct to the best of my knowledge and ability."

Signature_____Date_____/_____/_____

Professional License, Registration or Certification Number:

#_____ State_____

Clinic or Agency_____

Address_____Suite_____

City_____State_____Zip_____

Phone (____) _____

Please return this medical verification to the applicant.

Thank you.