TARC3 Medical Form ***(Vision Disabilities)***

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 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 applicant's last physical evaluation: ___/___/___

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

____

____

2. Best Corrected Vision: O.D. 20/_____ O.S. 20/_____ O.U. 20/_____

3. Visual Field Deficit: O.D. ______° O.S. ______°

4. What is the prognosis? Is the condition stable, degenerative, or otherwise changing?

____

____

5. Is the individual able to walk outdoors alone? ___ Yes ___ No

Explain____

____

If yes, where can the applicant walk:

__ Only on his/her own property and to familiar places

__ To places nearby (for example, on the same block)

__ To places farther away

6. If applicant is able to travel outdoors alone, is he/she able to cross streets without help?

__ At quiet streets with very little traffic __ At traffic lights

__ At busy intersections __ With auditory cross signals only

__ Other____

If the applicant is partially sighted:

7. Is he/she able to see steps or curbs? __ Sometimes __ Often __ Never

8. Is his/her vision affected by different lighting conditions?

__ Bright sunlight __ Dimly lit or shaded places

__ Nighttime __ Other____

9. Is the applicant's ability to travel outside alone affected by other conditions?

__ Yes __ No *(Consider impact of environmental noise and ability to distinguish traffic flow patterns.)* Please explain: ______________________________________

____

over

10. **Please verify information about any orientation and mobility training or travel training started or completed. Based on such training, please identify places where you feel this applicant is able to travel independently.**

A.____

____

B.____

____

C.____

____

If the applicant has not received any mobility or travel training:

11. Do you believe that the applicant would benefit from mobility instruction or travel training?

__Yes __No Explain: ____

____

____

12. TARC3 drivers assist passengers from the door of their origin to the van, and from the van to the door of their destination. When traveling, does the applicant need additional assistance from a personal care attendant?

___Yes ___No If "yes", please describe the type of assistance needed:

____

____

____

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_______________________________

Phone (____) ________ - ______________

Address____

Suite__________________

City____________________________ State________ Zip______________

***Please return this medical verification to the applicant.* Thank you.**