TRANSLINK

239 E BARNETT RD, MEDFORD, OR 97501

Ph: 541-842-2060 1-888-518-8160 Fax: 541-842-2063

ATTN: Fax: DATE:

RE: **DOB:** **Prime #:**

The above named person has requested sedan/wheelchair van transportation from TransLink, stating that he/she is unable to use public transportation. The goals of TransLink are to ensure that clients have access to medical care and to provide the most cost-effective method of transportation while still meeting each individual's needs. Medical transportation includes providing free bus fare to those who can use public transit.

Using transit would result in savings for the State of Oregon and allow for increased availability of sedans and wheelchair vans for people who require them to access medical services.

We understand that not all people can use the regular bus services due to specific physical or mental health condition(s). Please answer the following questions to assist us in determining the most cost-effective, appropriate method of transportation for this individual.

Please print legibly, and fax the completed form to 541-842-2063.

FUNCTIONAL ABILITIES	**Yes**	**No**	**Unknown**	**N/A**
1. Is this person able to wait outside while seated?	☐	☐	☐	☐
2. Is this person able to wait outside, standing for up to 15 minutes?	☐	☐	☐	☐
3. Is this person able to walk or propel their mobility device 10 blocks?	☐	☐	☐	☐
4. Is this person able to walk or propel their mobility device 5 blocks?	☐	☐	☐	☐
a. If not 5 blocks, how far? ___________________________				
5. Does this person have significant vision/hearing impairment?	☐	☐	☐	☐

a. If yes, please explain:

____

____

____

6. Are any of the above mentioned conditions temporary, and if so, for how long?

____

Is there any additional information you would like to share regarding this person's functional abilities?

____

____

____

____

RE: **DOB:** **Prime #:**

COGNITIVE ABILITIES

	Yes	No	Unknown	N/A
1. Is this person able to understand directions?	☐	☐	☐	☐
2. Is this person able to identify stops, buses, landmarks, etc?	☐	☐	☐	☐
3. Is this person aware of safety issues when alone?	☐	☐	☐	☐
4. Is this person able to appropriately seek out help, if needed?	☐	☐	☐	☐
5. Does this person have **severe** delusions/hallucinations causing safety issues/ concerns in public?	☐	☐	☐	☐

a. If yes, please explain:

____

____

____

	Yes	No	Unknown	N/A
6. Does this person have **severe** anxiety/panic causing safety issues/concerns in public?	☐	☐	☐	☐

a. If yes, please explain:

____

____

____

7. Are any of the above mentioned conditions temporary, and if so, for how long?

____

Is there any additional information you would like to share regarding this person's cognitive abilities?

____

____

____

____

I certify under penalty of perjury under the laws of the State of Oregon (ORS 162.065) that the information contained on this form is true and correct.

What date was this person last seen in your clinic?______________________________

Medical or Mental Health Professional's Signature ______________________ **Date** __________

Medical or Mental Health Professional's Printed Name ______________________________

TransLink
Quality Assurance Department
Ph: 541-842-2062
Fax: 541-842-2063