

Aspire Canterbury Taxi Mobility Pre-Assessment Medical Form

For use by Medical Practitioners only

(We ask Medical Practitioners to provide this information before we contact an applicant to enable us to assess an individual's eligibility for this scheme. If they meet the criteria, we will contact the applicant direct using the information you have provided)

Applicant Details (PLEASE PRINT)

Title: _____ Surname: _____

First Name (s): _____

Address: _____

Phone: _____ Date of Birth: _____

(An eligible person must have an impairment that prevents them from undertaking any one or more of the defined components of a journey unaccompanied, on a bus, train, or ferry in a safe and dignified manner for SIX MONTHS OR MORE)

Are they in your opinion able to complete the following tasks?	Yes	No
Walk a distance of 500m without assistance	<input type="checkbox"/>	<input type="checkbox"/>
Stand up for 10 minutes without assistance	<input type="checkbox"/>	<input type="checkbox"/>
Remain seated and travel securely on a bus	<input type="checkbox"/>	<input type="checkbox"/>
Step up onto and down from a bus	<input type="checkbox"/>	<input type="checkbox"/>
Get to the final destination point	<input type="checkbox"/>	<input type="checkbox"/>
Travel on an accessible bus if it was available	<input type="checkbox"/>	<input type="checkbox"/>

If "NO "to any of the above tasks, could you please outline their medical condition which prevents them from undertaking that task?

I confirm that the condition will last longer than 6 Months

Practitioners Signature: _____

Date: _____

E: totalmobility@aspirecanterbury.org.nz

Aspire Canterbury Fax: 03 379 5939

MEDICAL PRACTITIONERS STAMP
